Physicians' Newsletter

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Medical Office Assistant Billing Seminars are back

- Ask the experts – Ministry of Health and HIBC personnel will be on hand to provide information on a broad range of billing topics including incentive fees and service charges.
- Share concerns – participate in open session discussions and get answers to all your questions.
- Meet and mingle with other MOAs in your community.

The Medical office assistant (MOA) billing seminars are scheduled for September and October 2007. Confirmation of dates, times and locations will be coming soon. Please continue to check the MSP Web site for more information and watch for the online registration form:

http://www.health.gov.bc.ca/msp/infoprac/physbilling/index.html

A broadcast message will also be issued to MOAs with complete information about the billing seminars.

We look forward to seeing you at one of the sessions.

Has your office address changed?

Please notify the College of Physicians and Surgeons of British Columbia when changing your practice location. The College will notify the Medical Services Plan (MSP) of physician address changes. Your registered address with the College will be used as your official registered address with the MSP.

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MSP BULLETIN – Spring 2007

The Medical Services Plan's "Bulletin" is provided to help physicians identify patients whose MSP benefits have payment restrictions. This Bulletin provides important billing information for physicians only. Thank you for respecting the confidential nature of this information.

The Bulletin is an updated listing of restricted MSP enrollment numbers for clients who have signed a legal "Agreement of Limitation" form, which limits MSP payment responsibilities to one primary care physician. If care is provided by other physicians, the charges must be made directly to the clients. MSP will not accept payment responsibility unless special circumstances are clearly stated. An example of this would be medical care that has been provided by an emergency physician in the hospital emergency room.

MSP is concerned about the potential misuse of CareCards and strongly recommends a complete check of CareCard information at all first appointments. If you suspect any unusual use of a CareCard, please request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

PHN	Birthdate (MM/YY)	Sex	Physician Number
9013676868	12/54	M	06541
9025293026	12/58	M	24287
9029596344	09/55	M	00792
9030165823	12/54	F	05334
9030780581	05/29	F	08241
9030861738	10/45	M	01604
9032398914	08/56	M	09760
9032842679	05/59	F	01229
9034793801	06/59	F	06468
9041726364	07/56	F	03733
9071584167	06/48	M	09604
9104870848	04/67	F	09443
9107346403	08/54	M	08365

BCMA Pregnancy Leave Program

Are you a physician practicing medicine in British Columbia?

Are you having a baby or planning a pregnancy in the period of April 1, 2007 to March 31, 2008?

If you are, then it is important to take advantage of the Pregnancy Leave Program (PLP).

The PLP is the new name of the Maternity Leave Benefit Program that was negotiated for you in the 2001 working agreement between the BCMA and the government of British Columbia and continued under the 2006 LOA. The PLP provides a benefit to assist new mothers while recovering from pregnancy and delivery. Application for benefits must be made no later than 8 weeks after the birth of your baby.

For more information, contact:

Lorie Arlitt, PLP Administrator
Toll Free in BC: 1 800 665-2262 (Ext 2882)
Direct Line: 604 638-2882
Email: larlitt@bcma.bc.ca

The British Columbia "No CPR" Form and Bracelet

Enclosed with this Newsletter is a copy of the Ministry of Health's No CPR Form and a one page MedicAlert® order form for requesting copies of MedicAlert®'s new "No CPR Bracelet" brochure, which explains the process for ordering a No CPR bracelet.

Since the mid-nineties, British Columbians who have been diagnosed as having a terminal illness or are considered to be near the natural end of life have had the option of asking their physician to complete a No CPR Order on a specified BCMA/Ministry of Health form. The recently updated No CPR form includes references to the No CPR bracelet and reflects applicable consent provisions of the Health Care (Consent) and Care Facility (Admission) Act, which came into effect on February, 2000. Physicians can order free copies of the triplicate No CPR form (HLTH 302.1 Rev. 2007/03/05) from the Government's Product Distribution Services Customer Service at Fax: 250-952-4442.

To ensure a means of ready verification that a No CPR order is in place, the Ministry of Health and the BCMA agreed several years ago to extend the No CPR protocol by adding a bracelet component. This means that any person for whom a No CPR form has been completed will be able to purchase a No CPR bracelet from the Canadian MedicAlert Foundation (MedicAlert®). A Vancouver philanthropist has kindly agreed to cover the cost of No CPR bracelets for those individuals who are unable to pay for it themselves.

Please use the enclosed order form to obtain MedicAlert® brochures and keep the sample No CPR form for ready reference. For additional information please contact Pieter de Groot, BC Ambulance Service: pieter.degroot@gov.bc.ca

Pacific Coastal Airlines Joins the Ministry's Travel Assistance Program

The Ministry of Health is pleased to announce that Pacific Coastal Airlines is now offering special medical fares to BC residents presenting approved Travel Assistance Program (TAP) forms for point-to-point travel between Vancouver and cities served by the airline.

As of March 15, 2007, Pacific Coastal Airlines' "Med Fares" can be purchased up to any time before scheduled flight departure with immediate credit card payment and approved TAP confirmation number. The tickets, which are approximately 30% off regular fares, are fully refundable, with no change or cancellation fees. Pacific Coastal Airlines flies to Vancouver from Anahim Lake, Bella Bella, Bella Coola, Campbell River, Comox, Cranbrook, Klemtu, Masset, Port Hardy, Powell River, Terrace, Trail, Victoria, and Williams Lake.

Physicians practicing in the locations/vicinities listed above may wish to inform their patients of this travel option when providing them with a TAP form to obtain specialist services located in the Greater Vancouver area.

Immunization Injections for Patients under 18 years of age

The Medical Services Commission supports a new initiative providing payment to physicians for immunization services, for patients 18 years old of age and younger. The new fee items are listed in an insert included with this newsletter titled "Update to the Medical Services Commission Payment Schedule." If there are questions about how to bill the new fee items, please contact Health Insurance BC (HIBC), Billing Support at:

Vancouver:	604 456-6950
Other areas of B.C. (toll-free):	1 866 456-6950

Please note that the patient must be seen by a physician in order to bill an assessment fee for the service. Multiple injections may be billed when performed during the same office visit. It would be inappropriate to bill for subsequent office visits for separate injections.

Health Insurance BC – Who we are and what we do for MSP Providers

Since April 2005, the Medical Services Plan (MSP) and PharmaCare Operations, collectively known as Health Insurance BC (HIBC), have been administered by MAXIMUS BC. In this alternative service delivery arrangement the Ministry of Health sets policy, establishes standards and monitors HIBC performance to ensure that it meets contractual requirements. Health Insurance BC administers MSP and PharmaCare operations through the management of program information, claims, contact centre services, documents and information technology. At Health Insurance BC, we are focused on improving customer service, providing greater operational efficiency, and modernizing technology.

What We Do for MSP

The following stats will give you an idea of the breadth of service we provide. As of February 28, 2007, under the MSP program, we:

- have assisted approximately 12,700 providers;
- dealt with over 4,300 provider computer sites from which claims are electronically submitted;
- processed 85 million provider claims a year;
- processed approximately $103 million of provider payments twice each month; and
- handled approximately one million paper forms annually – process basic applications, registrations and status changes.

How We Are Held Accountable

Since day one, we have been committed to meeting our service objectives. Through our agreement with the Ministry we must meet 27 detailed service level requirements. These requirements, or performance levels, were jointly agreed upon and are monitored and reported on a monthly basis.

What This Means for Our Customers

We have initiated several key infrastructure improvements, cross-trained our staff, and improved public access to Ministry of Health programs through improved telephone service and greater electronic access. Thanks to the work of our dedicated staff, the service levels for the past year have been substantially met or exceeded.

For MSP, to highlight a few:

- we have worked toward eliminating telephone busy signals entirely;
- for 18 consecutive months we have maintained an average of less than a minute to answer telephone inquiries from health care providers
- 99% of all documents were processed in 20 business days – decreasing the processing time for MSP enrolment, premium assistance and account maintenance processing;
- we reduced the general public document inventory to record lows;
- for over a year and a half we have maintained the necessary technology to ensure uninterrupted services; and
- we continue to maintain the pharmacy payment schedule.

What You Can Expect From Us

Health Insurance BC remains committed to identifying and implementing process improvements to ensure service levels are maintained. We strive to ensure British Columbians and health care providers receive the best service possible.

Thank you for working with us to make this possible.

New - IVR Option for Diagnostic Facilities

A new option was implemented April 2, 2007 through the MSP Practitioner Information Line (IVR) allowing diagnostic facilities to check Facility/Practitioner connections.

If after 10 days of submitting your form you are still unable to confirm your facility/practitioner connection through IVR, please refax the form.

Diagnostic facilities who do not follow-up on rejected claims due to no Facility/Practitioner connectivity should not expect overage ("A" code) claim approval if the time period exceeds 90 days from the date of service.

Victoria:	250 383-1226
Vancouver:	604 669-6667
Other areas of B.C. (toll-free):	1 800 742-6165

Echocardiography Payment Policy

The policy restricting the performance of echocardiography to hospital-based facilities for MSP payment has been amended by the Medical Services Commission.

MSP payment for echocardiography will now be considered for Health Authorities that contract with accredited private facilities or for echocardiography performed in hospital-operated free standing satellite facilities.

Process

1. Health Authority/Hospital-Operated Free Standing Echocardiography Laboratories
   a. Completion of the Medical Services Commission/Health Authority Division Application for New/Expanded Out-Patient Diagnostic Services
   b. Claims must be submitted under the Certificate/facility number issued for the specific address of the off-site facility.

2. Contracted Echocardiography Services
   a. Applications submitted by a Health Authority/hospital for approval of contracted echocardiography services should include:
      i) the name of the facility to be contracted
      ii) the name(s) of the physician(s) providing the echocardiography services
      iii) the number of services for which the contract has been made
      iv) the time period for the term of the contract

Billing Rules

1. Claims will be submitted by the hospital in the Health Authority overseeing the off-site facility or contract using a unique facility number issued by the Medical Services Commission to the Health Authority/Hospital specifically for the contracted service along with the practitioner number of the physician providing the echocardiography service.

2. The Medical Services Commission is not liable for payment to private echocardiography facilities contracted by a health authority/hospital. Payment to a private facility for contracted echocardiography services is the responsibility of the Health Authority/Hospital.

Re-Submitting Claim for Reassessment of Payment

If you disagree with how MSP has paid or refused a claim, to have the claim reassessed you are required to re-submit the claim with a note record indicating that you are requesting a reassessment and include a brief explanation.

Re-submitted claims must be within 90 days of the remittance statement date and submission code X must be used with a note record. If paper correspondence related to the re-submission has been sent, "correspondence sent" should be indicated in the claim comment field.

If you are dissatisfied with the result after re-submitting the claim, please advise Claims Billing Support by phone, fax, or mail, at:

Telephone:
Greater Vancouver area: 604 456-6950
Elsewhere in B.C. (toll-free): 1 866 456-6950

Facsimile: 250 405-3593

Mailing address:
Claims Billing Support
Health Insurance B.C.
P.O. Box 9480 Stn Prov Govt
Victoria, B.C. V8W 9E7

New and Modified Explanatory Codes

New Explanatory Code

LA Volume discount mechanism applied as per 2007 renewed lab agreement.

LR This service is included in the annual complex care block fee.

Explanatory Code – Wording Change

FO The sex of the patient does not correspond with the fee item/diagnostic code.

New WCB Explanatory Codes

O2 WCB Refused. This services does not meet the criteria for fee item billed. If clarification required contact WCB payment services department.

N9 WCB Refused. Call out charges not payable for service(s) billed.

Implementation of Client Assessment Tools

In January 2001, the British Columbia (BC) Ministry of Health mandated implementation of two client assessment tools in a provincial initiative to standardize the assessment of home and community care clients and improve their quality of care. Implementation of the tool for home care clients in the province was completed April 1, 2005. Implementation of the Resident Assessment Instrument/Minimum Data Set 2.0 (RAI/MDS 2.0) for clients in residential care facilities is in progress and to be completed by March 31, 2009.

The first RAI/MDS assessment tool was developed in the United States in 1988 in response to the desire to improve patient assessment and care delivery in nursing homes. Since then, a suite of Resident Assessment Instruments have been developed by an international health care research team of home and community care experts, and are currently being used in 18 countries. The two instruments have been modified for Canadian context and are in use or are in the process of being put into practice in most Canadian provinces.

The RAI/MDS tools provide a comprehensive core assessment that reflects a client's physical, cognitive, emotional and social status. This assessment identifies the client's care needs, enhances quality of care, and provides important information to all health care providers for care planning. As an outcome of the assessment process, specific problem areas that require further clinical assessment are high lighted. These assessment tools also generate the clinical status of clients, and include the Cognitive Performance Scale and the Depression Rating Scale.

A provincial committee comprised of Ministry of Health and health authority representatives, established to coordinate the implementation of the RAI/MDS tools throughout BC, is currently focused on the implementation of the residential care tool. Each health authority has formed its own working group to plan and implement a smooth transition from current assessment practices to the use of the new tool in facilities within their Health Authority. As well, all professional direct care staff who will be involved in completing the RAI/MDS 2.0 assessments are taking part in a standardized education process. Each health authority will be contacting family physicians within their region to provide information regarding the implementation of RAI/MDS 2.0.

With the implementation of the new residential care tool physicians will be able to access comprehensive and standardized information for their residential care clients in 2009. The introduction of these assessment tools will not affect the way in which physicians provide care to patients and does not influence the billing of physicians' visits in any manner.

Enhancing care delivery is a goal of all health care professionals, and the implementation of the home care and residential care facility RAI/MDS tools throughout the province is an effective way to help achieve quality care for home and community care clients in British Columbia. For additional information about these tools, visit the Canadian Institute for Health Information's Web site at: http://www.cihi.ca.

Audit Report General Practice: Dr. A.

A GP came to the attention of the Billing Integrity Program because of a high incident of 'family constellation' billings, in which members of the same household received same day services from the physician. The peer medical inspector found that the visits were medically justified, but that many medical records were indecipherable and that records of multiple family members were combined in a single chart. This raised potential privacy and quality of care concerns which were reported to the College of Physicians and Surgeons of BC. The inspector also noted some evidence of over servicing.

As a result of a negotiated settlement, the physician agreed to repay the Commission $6600, inclusive of audit costs and interest, and abide by a pattern of practice order in which the physician will maintain adequate and legible records, maintain a distinct chart on each patient, and otherwise comply with the MSC Payment Schedule requirements.

PharmaCare Updates

Important Reminder – CPSID Required on All Prescriptions

PharmaCare continues to receive well over 1700 calls each month from pharmacies who have been asked to fill a prescription that does not include the prescribing physician's College of Physicians & Surgeons Identity Number (CPSID). Accurate physician identification is important as this information will be included in a patient's PharmaNet medication history. Most commonly, the difficulty arises because the physician has:

- given their Medical Services Plan Billing Number instead of their CPSID, or
- used a generic pad (for a walk-in clinic, hospital emergency department, etc.) and failed to include their CPSID.

Physicians, please include your CPSID on all prescriptions, as set out in the College of Physicians & Surgeons Resolution 00-54 of September 1, 2000.

PharmaCare Special Authority Criteria on the Web

For the convenience of physicians and pharmacists, PharmaCare posts the Special Authority criteria for all Limited Coverage and Reference Drug Program medications on its website. The page for each medication, listed alphabetically by generic name, includes a direct link to the appropriate Special Authority form.

For quick access to the most current Special Authority criteria and forms, please visit the PharmaCare web site at www.health.gov.bc.ca/pharme and select the link for Special Authority Information.

Medical Practice Access to PharmaNet (MPAP) Survey Summary

Over 940 physicians have chosen to connect to PharmaNet since the province-wide Medical Practice Access to PharmaNet (MPAP) was launched in December 2005.

For information on what medical practices think of the service, please see the results of our MPAP survey included with this newsletter. Our thanks to the medical practices for taking the time to share their experiences using the MPAP service.

We would also like to thank Dr. Francis Lau, Associate Professor and Graduate Advisor, School of Health Information Science, University of Victoria, and the representatives from the B.C. Medical Association and College of Physicians and Surgeons of B.C., for their assistance in peer-reviewing the report results.

For more information on the benefits of having access to patient PharmaNet medication profiles or to find out how to connect, visit the Ministry of Health's Data Access Services MPAP web page at www.health.gov.bc.ca/ehealth/das/medpract.html or send an e-mail to HLTH.DataAccessServices@gov.bc.ca.

Changes to the Newfoundland and Labrador Medical Care Plan Cards

Please check to ensure that patients visiting from Newfoundland/Labrador present the new card.

The Newfoundland and Labrador Medical Care Plan (MCP) is currently issuing new MCP Cards. The new card contains information such as a twelve digit health insurance number, the beneficiary name, gender and date of birth, as well as effective and expiry dates.

- Physicians and Hospitals should be aware that effective August 1, 2007 claims for services rendered to beneficiaries of Newfoundland and Labrador on and/or after that date who do not present a new MCP card should not be submitted for processing through the inter-provincial billing processes.
- The expiry date is required to support invoicing hospital claims for services provided on/or after August 1, 2007.

The Full Service Family Practice Incentive Program

Improving and Sustaining B.C.'s Primary Health Care System

The General Practice Services Committee (GPSC) was established in 2002 as a vehicle for the Ministry of Health, the BC Medical Association and the Society of General Practitioners of BC to work in partnership to develop innovative solutions to support and sustain full service family practice in B.C.

In 2003, the GPSC launched the Full Service Family Practice Incentive Program in response to survey feedback from B.C.'s family physicians that they were finding it increasingly difficult to provide proactive, planned care to their chronically ill patients, and that women were experiencing difficulties finding a GP in their community who would deliver their babies due to the dwindling number of B.C. GPs providing maternity care. In 2006, the GPSC further expanded the existing two initiatives and introduced additional incentives to support GPs in providing care to the frail elderly, people with complex chronic illness, chronic mental illness and/or addictions, and those requiring end of life/palliative care. The following initiatives are available for eligible patients through the *Full Service Family Practice Incentive Program:*

- The annual **Chronic Condition Payment** supports family doctors in providing evidence-based BC Guidelines recommended care for their patients with diabetes and/or congestive heart failure ($125), and hypertension ($50). This funding compensates GPs for the patient chart review and managed care planning time that occurs outside of the usual office visit.
- To help ensure that women have access to maternity care in their communities, GPs providing this vital service are eligible to receive the **Obstetric Care Premium.** This premium provides a 50% bonus on the current value of GP fee-for-service delivery and attendance at emergency and elective C-section fee items 14104, 14109 and 14108 to a maximum of 25 births per calendar year. **The Maternity Care Network Payment** ($1500 per quarter) is also available in recognition, and support of GPs working within a group practice approach to maternity care that ensures that a GP is always available to deliver their patients.
- GPs caring for the frail elderly, people with complex chronic illness, chronic mental illness and/or addictions, and those requiring end of life/palliative care often need to case conference with other health care providers and families about their patients who are residing in a facility. In addition, many complex patients live in the community and need a clinical action plan to help ensure they receive appropriate care, from the appropriate health care provider, in a timely manner. In response, the **Facility Patient Conferencing Fee**, and the **Community Patient Conferencing Fee**, respectively, are available to support GPs for the time they spend in coordinating their patient's care and in collaborative planning.

New – Available April 1, 2007!

Innovations to Better Support Full Service Family Practice and Optimal Patient Care.

In 2005 and 2006, through the Professional Quality Improvement Days, the GPSC conducted a province-wide consultation of BC GPs on how to best support and sustain the province's primary health care system. 1000 BC GPs responded -- Pay Us. Value Us. Train Us. Support Us.

In response, the GPSC is introducing the following innovations in support of improved patient care and recognition of full service family practice (funded through the Ministry of Health/BC Medical Association 2006 Agreement allocation for full service family practice.

- Care of patients living with more than two chronic illnesses is often complex and demanding. People living with more than two chronic illnesses often have a poor quality of life due to their illness, and face significant challenges in navigating the health system to effectively meet their health needs. To better support thoughtful treatment planning based on patient goals and improved care coordination, the Full Service Family Practice Incentive Program now includes the **Complex Care Payment** to better enable GPs:
  - to take time to reflect on the needs of their complex patients;
  - develop treatment plans in collaboration with the patient and their support network; and

- where needed, coordinate and/or become an active member of a broader care team focused on assisting the patient to manage their multiple conditions.

Each GP will be paid $315 per calendar year per** high risk patient in specific priority disease **categories, and can choose from either of the following two payment options:

Option 1

Complex care fees are paid in addition to office **visit fee:**

- Visit 1: review of chart and development of personal care plan incorporating patient's values and personal health goals = $100
- Visit 2: Follow-up on targets set, patient experience, clinical review – plan adjustments = $35
- Visit 3: Follow-up with patient = $35
- Visit 4: Review of personal care plan = $75
- Visit 5: Follow-up with patient = $35
- Visit 6: Follow-up with patient = $35

Option 2

Complex care payment of $315 annually plus a block payment equivalent to six visits per year:

This option provides more flexibility in the provision of care based on physician and patient preference, and style of practice to meet the patients' needs. Care is not limited to face-to-face interaction with the physician, and can also include group patient clinical visits, visits with another health professional, and can be supplemented by non face-to-face interaction with the patient or patient's care provider through telephone or email contact.

- Approximately half of B.C.'s population is at risk for and/or been tested for a chronic illness. Many diseases, such as diabetes and cardiovascular disease, have common risk factors (unhealthy eating, sedentary lifestyle, tobacco and alcohol use), that if addressed early could prevent the onset of chronic illness. Family physicians want to provide preventative care to their patients, and most can readily identify those individuals in need of intervention. In response, the Full Service Family Practice Incentive Program now includes a Prevention Fee that supports GPs in conducting a cardiovascular risk assessment and patient follow-up. Men ages 40-49, and women between 50-59 years, are eligible to receive a cardiovascular risk assessment based on minimum age, gender, smoking status, fasting blood sugar, blood pressure, and lipid profile.

During the Professional Quality Improvement Days province-wide GP consultation, family physicians indicated that incentive payments will not result in fundamental changes to primary care in and of themselves – support is also needed in order to change clinical practice and the health care delivery system. Using funding allocated for non-physician compensation under the 2006 Agreement, the GPSC is introducing the two-year **Practice Support Program**. Starting May 2007, B.C. GPs wishing to modernize their clinical practice can access training and change management assistance in implementing an open access office scheduling system, use of patient registers, implementing chronic disease management quality improvement, and other office workflow changes.

For more information about the Full Service Family Practice Incentive Program, visit:

www.primaryhealthcarebc.ca.
www.bcma.org/PracticeSupportProgram.htm.
www.bcma.org/PracticeSupportProgram.htm

Coming Soon!
The GPSC will be further expanding the Full Service Family Practice Incentive Program to offer:

- A Maternity Training fund to support family physicians wishing to update their maternity skills.

- The GP Attract and Retain program to encourage recent graduates to pursue family practice in areas of BC in need of GPs.

Spring 2007 – Inserts

- Update to the Payment Schedule
- PharmaNet Information
- No CPR brochure
- MedicAlert Order Form
- Complex Care Fees
- Preventative Fees
- eHealth and PharmaNet — Building Electronic Health Records for B.C. Residents

Renewed Laboratory Agreement between the BC Medical Association and the BC Government now signed

The BC Medical Association and the BC Government signed the *Renewed Laboratory Agreement* in early 2007. The agreement is effective January 1, 2007 to March 31, 2010 and supersedes the *Letter of Agreement on Lab Reform and Fee Review* signed on July 27, 2004.

The *Agreement* will result in:

- fee changes for laboratory services at public and private laboratories, effective February 1, 2007; and
- high volume discounts of 55 fee items, effective April 1, 2007.

The purpose of the changes is to provide stability and structured improvement in the BC laboratory system.

A printable copy of the payment schedule is available in a PDF format under Laboratory Medicine at:

http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Frequently Asked Questions (FAQ's)

General Information

Q: What is the purpose of these changes?
A: The purpose of the changes is to provide stability and structured improvement in the BC laboratory system.

Q: How does this agreement result in fee changes?
A: Overall, there will be a 3.5% permanent reduction applied to the Revised and Adjusted Laboratory Payment Schedule rates, effective January 1, 2007. The reduction will be applied differentially across the schedule, excluding specified items, thus resulting in an effective 3.61% reduction to the remaining items.

Q: Does this new agreement supersede the Letter of Agreement on Lab Reform and Fee Review signed on July 27, 2004?
A: Yes, it replaces the 2004 Letter of Agreement.

Q: How does this agreement relate to the 2006 Agreement with the BCMA?
A: This agreement is consistent with the 2006 Agreement. The 2006 Agreement excludes Laboratory Services Fees from increases in effect on March 31, 2006. Laboratory Services Fees are not excluded from the increases identified for 2007/8 to 2009/10.

Q: Will there be fee item increases for laboratory services for 2007/8 to 2009/10 as part of the 2006 Agreement with the BCMA?
A: Any future fee increases for laboratory services will be proposed by the BCMA. Details regarding individual fee items are yet to be determined.

Expenditure Targets

Q: What are the expenditure targets?
A: The total annual outpatient fee-for-service lab expenditure targets are as follows:

2006/2007:	$274.9 M
2007/2008:	$269.7 M
2008/2009:	$284.4 M
2009/2010:	$300.3 M

Q: What fee items are included in the target expenditures?
A: The targets include expenditures for Medical Services Commission insured laboratory medicine fee items as listed in Appendix A of the Renewed Laboratory Agreement. The targets do not include expenditures for ECG and Nuclear Medicine items.

Timing

Q: When is the effective date for this agreement?
A: The agreement is effective January 1, 2007 to March 31, 2010.

Q: When can I bill under the new fee prices?
A: You can bill under the new fee prices as of February 1, 2007 commencing with the February 1, 2007 date of service.

Q: As the agreement is effective January 1, 2007, are you going to adjust the laboratory services paid at the old amount for January 2007 service dates?
A: No, the new amounts become effective with the February 1, 2007 date of service.

Q: What will happen to my claims billed under the old rates?
A: The MSP claims system will pay services commencing February 1, 2007 at the new rate. Payments will appear on the remittance statement with explanatory code BG-Amount adjusted to the rate effective for the date of service.

Volume Discount Mechanism

Q: Will the 20% volume reduction on laboratory fee items continue?
A: No, the new fee amounts have replaced the 20% volume reduction.

Q: Will I be notified when I have reached the 90% volume threshold being applied to the high volume laboratory fee items?
A: No, you will not be notified.

Q: Is there a list of the high volume fee items?
A: Yes, they are listed in the Renewed Laboratory Agreement under Appendix C.

Q: Does the high volume threshold apply to each individual payee number for private laboratories?
A: No, the volume threshold is applied to all billings from laboratories based on the laboratory ownership or health authority/health authority affiliation.

Q: Does the high volume threshold apply to each hospital?
A: No, the threshold is applied by health authority. The combined volume from each hospital in a health authority will be used to calculate the volume threshold.

Additional Information

Q: How do I obtain a copy of the laboratory fee item changes?
A: Contact your software vendor if you require an electronic version of the laboratory fee item changes.

A printable copy of the payment schedule is also available in a PDF format under Laboratory Medicine at: http://www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html

Q: Where can I view a copy of the Renewed Laboratory Agreement?
A: You can view a copy of the Renewed Laboratory Agreement at http://www.health.gov.bc.ca/msp/legislation/bcmaagree.html

Disclaimer – These FAQ's are for general information only. If discrepancies exist, the Renewed Laboratory Agreement (2007) takes precedence.

Pre and Post Operative Exams

The Preamble states that fees for surgery include the usual pre-operative preparation of up to one month's duration. This would include the pre-operative examination, the surgical procedure itself and post-operative follow-up, including removal of sutures and care of the operative wound by the surgeon or associate. Unless otherwise specifically indicated, the normal post-operative period included in the surgical fee is 42 days and the surgery fees include all concomitant services necessary to perform the listed service (including preparation of the operative site, incision, exploration, review of the results of diagnostic services rendered during the surgery, closure, and pre and post-operative discussion with the patient and/or patient's family).

Physicians' Disability Insurance – British Columbia Medical Association (BCMA)

Physicians' Disability Insurance

Coverage is not automatic. Physicians must apply and be approved by the insurer for coverage to take effect. Once approved, coverage remains in effect until the physician cancels the insurance, becomes ineligible for coverage or reaches age 65. Eligible physicians who are not insured are notified by BCMA each Fall.

Contact Information

BCMA Benefits

Email:	benefits@bcma.bc.ca
Telephone:	Lower Mainland: 604 736-5551 Toll Free in BC: 1 800 665-2262
Web site:	www.bcma.org

CMPA:

Telephone:	1 800 267-6522
Web site:	www.cmpa-acpm.ca

BRITISH COLUMBIA
The Best Place on Earth

Immunize

Dear Colleague:

RE: Medical Service Plan (MSP) Billing Code Changes for Childhood Immunizations

As you know, MSP has changed the billing code system for childhood immunization programs from newborns to children up to 18 years of age (inclusive). This was undertaken to recognize the important contribution physicians make to childhood immunization and to efficiently enhance the accurate and timely reporting of immunizations administered by physicians in B.C.

The new MSP fee is $3.00 per injection and MSP will pay for up to four injections per visit. New MSP codes are also vaccine specific to enable the collection of accurate immunization data. It is therefore essential that vaccine codes are entered into the MSP billing system accurately; and physicians are expected to continue reporting immunizations as per the established Health Authority process. Related to this, an eHealth project is currently underway to develop a Provincial Immunization Repository. It is anticipated that immunization data will eventually be transferred to this repository to provide more accurate data on immunizations and coverage rates in B.C.

Tools to assist you and your staff with monitoring, tracking and entering the new codes have been developed.

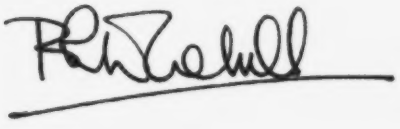
Please find included samples of the developed tools:

- Childhood immunization record for the patient chart.
- Reference card for billing (2)

An initial quantity of these tools will be available to you from your Health Authority (upon request). Updated versions are available and can be downloaded from the MSP website at **http://www.health.gov.bc.ca/msp/infoprac/physbilling/index.html**

You will also find a copy of the Canadian Paediatric Society resource *Your Child's Best Shot* in this package. It is the definitive guide to childhood vaccines presented in a format that is aimed at a parent's level of understanding. This tool is provided to assist you in conveying clear, reliable messages to parents so that they can make informed decisions about their child's health.

Thank you for participating in this important childhood immunization initiative.



Dr. Perry Kendall
Provincial Health Officer

BRITISH COLUMBIA
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Update to the Medical Services Commission
Payment Schedule

Preamble

Amendment

The wording of Section B. 4.e. vii) of the Preamble to the Payment Schedule is modified as indicated:

Long-Term-Care Institution Visits

When visits are required to patients in long-term-care institutions (such as nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities and personal care facilities, whether or not any of these facilities are situated on the campus of an acute care facility) claims may be made to a maximum of one visit every two weeks. It is not sufficient, however, for the medical practitioner simply to review the patient's chart. A face-to-face patient/medical practitioner encounter must be made. For acute concurrent illnesses or exacerbation of original illness requiring institutional visits beyond the foregoing limitations, additional institutional visits may be claimed with accompanying written explanation.

Out-of-Office Premiums

The cancellation date of the following provisional items has been extended, it will expire on March 31, 2008 or when replaced by a subsequent Minute whichever occurs first:

P01215	Evening (service rendered between 1800 hrs. and 2300 hrs.) - per half hour or major part thereof	$39.95
P01216	Night (service rendered between 2300 hrs. and 0800 hrs.) - per half hour or major part thereof	$60.14
P01217	Saturday, Sunday or Statutory Holiday (call placed between 0800 hrs. and 1800 hrs.) – per half hour or major part thereof	$43.98

Notes:

i) State time called and time service rendered.

ii) Where timing is continuous submit an account for each patient, indicating "CCFPP" (continuing care from previous patient)

iii) Not applicable to full or part-time emergency physicians or to on-site practitioners providing coverage in drop-in emergency clinics or hospital emergency rooms.

iv) When emergency services commence prior to 1800 hours (weekday) and extend beyond 1800 hours, anesthetic surcharges are applicable to the time after 1800 hours. Timing begins at 1800 hours and surcharge payments are based on one half hour of care or major portion thereof. Therefore the 01215 surcharge in these cases is payable after 15 minutes of continuous care (i.e. 1815 hours).

v) When emergency anesthetic services commence prior to 0800 hours and continue after 0800 hours, anesthetic surcharges are only applicable to the time prior to 0800 hours.

vi) *Anesthetic surcharges are applicable to services associated with elective surgery which, because of intervening emergency surgery, extends into or commences within the designated times.*

General Services

Amendment

Note iii) of the General Notes pertaining to Tray Service Fees is modified as indicated:

iii) Tray fees are not applicable when the service is performed at a funded facility (eg. D & T Centre, Psychiatric Institution, etc.)

New - Immunization Headings and Fees:

The following new heading and fee items have been approved on a provisional basis, effective January 1, 2007. This Minute will expire March 31, 2008, or when replaced by a subsequent Minute, whichever occurs first:

The following new heading and fee items are added subsequent to the "**Immunization Skin Tests**" section:

Immunizations for Patients 18 Years of Age or Younger

P10010	DTaP-P (Diphtheria, Tetanus, Pertussis, Polio	$3.00
P10011	DTaP-P-Hib (Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b).	$3.00
	Note: Not payable with P10010 or P10018 on the same day, same patient.	
P10012	Td (Tetanus, Diphtheria)	$3.00
P10013	TdP (Tetanus, Diphtheria, Polio)	$3.00
	Note: Not payable with P10012 or P10019 on the same day, same patient.	
P10014	TdaP (Tetanus, Diphtheria, Pertussis)	$3.00
	Note: Not payable with P10013 on the same day, same patient.	
P10015	Flu (Influenza)	$3.00
P10016	HA (Hepatitis A)	$3.00
P10017	HB (Hepatitis B)	$3.00
P10018	HiB (Haemophilus influenza type b)	$3.00
	Note: Not payable with P10011 on the same day, same patient.	
P10019	IPV (Polio Vaccine - Inactivated).	$3.00
	Note: Not payable with P10010, P10011 or P10013 on the same day,same patient.	
P10020	MEN-C-C (Meningococcal-Conjugate-C)	$3.00
P10021	MEN-P-ACYW135 (Meningococcal-Polysaccharide- ACYW135)	$3.00
P10022	MMR (Measles, Mumps, Rubella)	$3.00
P10023	PNEU-C-7 (Pneumococcal Conjugate C-7)	$3.00
P10024	PNEU-P-23 (Pneumococcal-Polysaccharide-23)	$3.00
P10025	RAB (Rabies)	$3.00
P10026	VAR (Varicella)	$3.00

Notes:

i) For immunizations of patients age 19 or older, use fee item B00010, B00034.

ii) Not payable for immunizations required for travel, employment and emigration.

iii) Payable per injection.

iv) *Payable in full with an office visit to a maximum of 4 injections per patient per day.*

v) *Not payable on the same day with B00010, B00034.*

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective May 1, 2007:

Amendment

The notes and payment rate following the specified listing is hereby amended:

T00039 Methadone treatment only $21.04

Notes:

i) *The physician does not necessarily have to have direct face-to-face contact with the patient for these fees to be paid.*

ii) *00039 is the only fee payable for any visit or medically necessary service associated with methadone maintenance therapy. This includes but is not limited to the following:*
   a) *At least one visit per week with the patient during the induction of methadone/methadone stabilization.*
   b) *At least two visits per month with the patient after induction/stabilization on methadone is complete.*
   c) *Case management/treatment planning with care team.*
   d) *Supervised urine drug screening and interpretation of results.*
   e) *Counselling by a physician.*
   f) *Communication with non-physician counsellor.*
   g) *Communication with dispensing/supervising pharmacist.*
   h) *Communication with primary care physician.*
   i) *Communication with hospital-based physician when patient admitted to hospital.*
   j) *Completion and submission of documentation relating to registration, termination or transfer.*

iii) *Claims for visit fees are not payable in addition.*

iv) *This fee is payable once per week per patient regardless of the number of visits per week.*

v) *This fee is not payable with out of office hours premiums.*

vi) *Eligibility to submit claims for this fee item is limited to physicians who:*
   a) *have a current valid license to prescribe methadone for addiction.*
   b) *are actively supervising the patient's continuing use of methadone within the provincial methadone program.*

vii) *This payment stops when the patient stops taking methadone.*

Diagnostic Services

Amendment

The following items are hereby amended by adding or revising the indicated note, effective January 1, 2007:

Section of Diagnostic and Selected Therapeutic Procedures

S00978 Percutaneous nephrostomy, procedural fee $239.77
Note: An Interventional Radiology Consultation is not payable unless the procedure is cancelled.

S00979 Percutaneous nephrostomy, with dilatation of tract for endoscopic urological manipulation, procedural fee $319.63
Note: An Interventional Radiology Consultation is not payable unless the procedure is cancelled.

S00980 Transhepatic biliary drainage procedure (includes 00857) $338.72
Note: An Interventional Radiology Consultation is not payable unless the procedure is cancelled.

S00981 Therapeutic radiological embolization $338.72
Note: An Interventional Radiology Consultation is not payable unless the procedure is cancelled

S00982 Percutaneous transluminal angioplasty $322.88
Note: An Interventional Radiology Consultation is not payable unless the procedure is cancelled.

S00983 Percutaneous abdominal abscess drainage by catheter insertion $220.53
Note: An Interventional Radiology Consultation is not payable unless the procedure is cancelled.

T00995 Embolization of brain and spinal cord AVM's $1868.30
Notes:
i) Tolerance testing (e.g., super selective Amytal test) performed during embolization is included.
ii) Includes functional testing in the awake patient.
iii) An Interventional Radiology Consultation is not payable unless the procedure is cancelled.

T00997 Detachable balloon embolization $1168.24
Notes:
i) To include all balloons placed during the procedure.
ii) Repeat procedures billable at 100%.
iii) An Interventional Radiology Consultation is not payable unless the procedure is cancelled.

T00998 Embolization of head, neck and spinal vascular lesions $1440.79
Notes:
i) T00995, T00997, and T00998 include the consultations associated with the procedure performed, preparation of the embolizing agent(s) and catheter(s), catheterization(s) and follow-up care of the patient by the radiologist.
ii) T00995, T00997 and T00998 are billable only by physicians with appropriate training in interventional neuroradiology.
iii) T00995, T00997 and T00998 are payable once per day, regardless of the number of embolizations or catheterizations performed, or balloons inserted.
iv) T00995 and T00998 include:
a. Diagnostic angiograms done during the procedure.
b. Angiograms performed as a separate procedure before or after the embolization are billable.

c. *Physicians may bill under miscellaneous fee code 00999 for each angiogram when done as part of an aborted embolization procedure. Each separate vessel injected will be considered a separate angiogram. Payment will be made at 100% for the first angiogram and 50% for subsequent angiograms, to a maximum of $1,700. Claims must be accompanied by written details of vessels injected.*

d. *Repeat procedures performed by the same physician and done within 30 days of the original procedure will be paid at 75% of the original fee.*

v) *An Interventional Radiology Consultation is not payable unless the procedure is cancelled.*

The following fee items are deleted, effective March 31, 2007:

S00791	Regitine test or histamine test – procedural fee
S00848	Radioactive myocardial perfusion study by cardiologist by direct coronary arteriography (extra)
S00924	Echo-encephalometry-interpretation

General Practice

Amendment

The cancellation dates of the following provisional items have been extended. This Minute will expire on Jan 31, 2008 or when replaced by a subsequent Minute, whichever occurs first:

P13020 Telehealth General Practitioner Assistant – Physical Assessment as requested by receiving specialist: - for each 15 minutes or major portion thereof $27.90

Notes:

i) Applicable only if general practitioner is required at the referring end to assist with essential physical assessment, without which the specialist service would be ineffective.

ii) Applies only to period spent during consultation with specialist.

Anesthesia

The cancellation date of the following provisional items has been extended, it will expire on March 31, 2008 or when replaced by a subsequent Minute whichever occurs first:

P01105 Anesthesia for cataract surgery – per 1 minute increment $2.00
Note: This item applies to fee codes 02188, 02190, 02192, 02196 and 22191.

P01165 Patients 80 years of age and over $24.96

Dermatology

P20210	Telehealth Consultation: To include history and dermatological examination, with review of any previous X-ray and laboratory findings and written report	$52.95
P20214	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee (laboratory test and biopsy when necessary, extra)	$36.15
	Note: Punch and shave biopsies are included in consultation or visit fees.	
P20207	Telehealth subsequent office visit	$21.89
P20208	Telehealth subsequent hospital visit	$20.87

Ophthalmology

P22010	Telehealth Consultation: To include history, eye examination, measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye-balance test, keratometry where indicated and necessary to prepare a written report.	$71.37
P22011	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit to the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.	$47.89
P22007	Telehealth subsequent office visit	$27.58
P22008	Teleheatlh subsequent hospital visit	$21.72

Otolaryngology

Amendment

Effective immediately, the description of the following listing is modified as indicated:

25300	Endoscopic stereotactic resection of intranasal or sinus tumour - up to 7 hours operation time	$1000.00 Anes Level 6
25301	- additional payment after 7 hours operating time	$250.00

Notes:

i) Fee items 25300 and 25301 are payable only when pre-operative radiological imaging indicates either distorted anatomy of the sinuses secondary to disease or injury, or revised complex anatomy resulting from prior surgery, such that without stereotactic guidance, the surgery could not be performed.

ii) Not payable for ethmoid disease, polypectomy or tumours affecting only one sinus.

iii) Includes all surgery necessary to access tumour.

iv) Payable only when rendered in acute-care facility.

v) Time over seven hours is payable under fee item 25301

vi) Minimum of 3 hours surgery duration required to bill fee item 25300.

vii) A written report must be submitted with claims billed under these items.

Internal Medicine

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective March 31, 2007:

Deleted Fee items:

The following fee items are hereby deleted:

00340	Scanning of eight hour electrocardiogram
00341	- professional fee
00342	- technical fee
00372	Measurement of bone mineral content in vivo using photon absorptiometry
S00758	Pneumoperitoneum – procedural fee
S00862	His bundle recordings and interpretations

The following fee items are deleted, effective April 30, 2007:

00395	Secretion smear for eosinophils
00396	Cells count – examination for faeces
00397	Fat, microscopic examination - faeces

Clinical Immunology and Allergy

The following fee item and fee heading are added, effective May 1, 2007:

30015	Secretion smear for eosinophils	$7.07

Rheumatology

P31110	Telehealth Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	$144.34
P31112	Telehealth Repeat or Limited Consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant, the consultative services do not warrant a full consultative fee	$72.62
P31106	Telehealth directive care	$40.00
P31107	Telehealth subsequent office visit	$44.99
P31108	Telehealth subsequent hospital visit	$29.10

Pediatrics

P50510	Telehealth Consultation: To consist of an examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	$158.25
P50511	Telehealth Consultation for complex behavioural, developmental or psychiatric condition in a child: To consist of a physical and neurological examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report.	$320.65

Notes:

i) Not to be billed when no change in condition from previous assessment.

ii) Minimum time requirement for service is 1.5 hours.

iii) Developmental delays include, but are not limited to: non-verbal learning disability, developmental reading disability, developmental coordination disability, developmental writing disability, dyscalculia, autistic spectrum disorders, fetal alcohol syndrome, mental retardation and other cognitive defects.

iv) Includes collection of data from collateral sources and formal screening, as appropriate.

P50512	Telehealth repeat or limited consultation: Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	$76.75
P50514	Telehealth prolonged visit for counselling *Note: The Plan will pay up to four such visits per year (see Clause B.4.c. of the Preamble).*	$59.36
P50506	Telehealth directive care	$38.23
P50507	Telehealth subsequent office visit	$48.86
P50508	Telehealth subsequent hospital visit	$38.64

New Fee Item

The following item has been approved on a provisional basis. This Minute will expire on March 31, 2008 or when replaced by a subsequent Minute:

P00545 Pediatric Case Conference – a formal, scheduled session/meeting, initiated at the request of the pediatrician, to discuss/plan medical management of patients with serious and complex pediatric problems, which may include family physicians or hospital staff (if an in-patient) or a relative and must include at least one professional or community agency representative.
– per ¼ hour $39.75

Notes:

i) Patient must be 18 years of age or younger.

ii) For services related to:
- *a. psychiatric disorders*
- *b. developmental disorders*
- *c. major chronic disease*
- *d. pre-transplant (concerning donor/recipient assessment)*
- *e. end of life*
- *f. multiple medical handicaps*

iii) Maximum of one hour may be claimed per patient per day.

iv) Not to exceed a maximum of two hours per patient per year.

v) The case conference must last at least 30 minutes to submit a claim.

vi) The results of the case conference must be recorded in the patient's chart along with the start and end times of the conference, as well as the names and job titles of the other participants at the meeting.

vii) This fee is not payable to physicians who are employed or who are under contract to a facility, agency or program (ie: Ministry of Children and Families' FAS, autism and child abuse or neglect assessments, HEAL, health authorities) who otherwise would have attended the conference as a requirement of their employment with the facility, agency or program.

viii) This fee is payable when the care conference occurs in person (ie: not payable when service provided by telephone or telehealth).

ix) *A visit or consult may be payable for the same patient on the same day as a case conference, provided the two items are consecutive, not concurrent, and start and end times are provided for both. A note record must be submitted for consults and patient management conferences occurring on the same day.*

x) *It may not be claimed unless the pediatrician has seen the patient within the previous180 days.*

xi) *Not payable within 3 months of fee item 00511 without a note record explaining the medical necessity.*

xii) *If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods and services are to be claimed under the PHN of each patient for the specific time period.*

xiii) *Start and end times must be included in time fields.*

Psychiatry

Full Telehealth Consultations:

P60610	Telehealth Individual full consultation: Diagnostic interview or examination, including history, mental status exam and treatment recommendation, with written report	$189.95
P60613	Telehealth Geriatric consultation (patients 75 years or older)	$256.46
P60622	Telehealth consultation – Emotionally disturbed child: Diagnostic interview or examination, including mental status and treatment recommendation, assessment of parents, guardian, or other relatives and written report	$320.65

Repeat or Limited Telehealth Consultations:

Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.

P60625	Telehealth – Individual consultation	$93.91
P60614	Telehealth – Geriatric consultation	$128.21
P60626	Telehealth – Emotionally disturbed child	$160.33

Telehealth Psychiatric Treatment:

P60607	Telehealth office visit to include services such as chemotherapy management and/or minimal psychotherapy	$39.75
P60608	Telehealth hospital in-patient visit	$46.62

Individual Telehealth Psychiatric Treatment:

P60630 - per 1/2 hour	$79.46
P60631 - per 3/4 hour	$110.74
P60632 - per 1 hour	$141.81

Family/Conjoint Telehealth Therapy – (two or more family members):

P60633 - per 1/2 hour	$84.68
P60635 - per 3/4 hour	$118.01
P60636 - per 1 hour	$151.19

Miscellaneous:

P60624	Evaluation interview with family member without presence of patient – per 1/2 hour session	$72.99
P60645	Patient Management Conference - meeting by specific appointment to discuss/plan patient management with third parties, which may include referring physicians or hospital staff (if an inpatient) or relatives and must include at least one professional or community agency representative - per 1/4 hour	$39.75

Notes:

a) Not to exceed a maximum of two hours per patient per psychiatrist, per calendar year.

b) A written record of the meeting must by maintained and/or a report generated by the psychiatrist.

c) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.

Plastic Surgery

P66010	Telehealth Major consultation: To include complete history and physical examination, review of X-ray and laboratory findings, if required, and a written report	$64.73
P66012	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six (6) months of last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	$35.58
P66007	Telehealth subsequent office visit	$21.45
P66008	Telehealth subsequent hospital visit	$18.28

The following modifications to the Payment Schedule are approved, effective immediately:

C61158	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving major muscles	$746.48 Anes.Level 5

Note: The following muscle flaps are payable under this item:

i) biceps femoris flap
ii) deltoid flap
iii) external oblique flap
iv) gastroocnemius flap
v) gluteus maximus flap
vi) gracilis flap
vii) latissimus dorsi flap
viii) pectoralis major flap
ix) rectus abdominus flap
x) rectus femoris flap
xi) soleus flap
xii) trapezius flap
xiii) temporalis flap
xiv) tensor fascia lata flap
xv) triceps flap
xvi) vastus lateralis flap
xvii) vastus medialis flap

C61157 Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving medium muscles $560.08 Anes. Level 5

Note: The following muscle flaps are payable under this item:

i) brachioradialis flap
ii) coracobrachialis flap
iii) pectoralis minor flap
iv) peroneus brevis flap
v) peroneus longus flap
vi) platysma flap
vii) sartorius flap
viii) serratus flap
ix) sternocleidomastoid flap
x) tibialis anterior flap
xi) tongue flap

C61156 Mocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving small muscles $373.39 Anes Level 5

Note: The following muscle flaps are payable under this item:

i) abductor digiti minimi flap
ii) abductor hallucis flap
iii) abductor pollicis brevis flap
iv) anconeus flap
v) extensor digitorum communis flap
vi) extensor digitorum longus flap
vii) extensor hallucis longus flap
viii) first dorsal interosseous flap
ix) flexor carpi ulnaris flap
x) flexor digitorum brevis flap
xi) flexor digitorum longus flap
xii) flexor hallucis longus flap
xiii) orbicularis oculi flap
xiv) orbicularis oris flap

General Surgery

The following modifications to the Payment Schedule are effective December 15, 2006:

Amendment

The following fee items are hereby amended by assigning a "C" prefix:

C72623	Limited resection of colon – laparoscopic
C72625	Hemicolectomy; right – laparoscopic
C72631	Hemicolectomy; left – laparoscopic
C72633	Sigmoid resection – laparoscopic
C72652	Reconstruction Hartmann procedure with or without protective colostomy -laparoscopic
C70603	Diaphragmatic or other hernia to include fundoplication, vagotomy and drainage procedure where indicated: – laparoscopic
C71535	Oesophagogastric fundoplasty (e.g. Nissen, Belsey IV, Hill procedures); antireflux: - laparoscopic

C71537	Oesophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure); abdominal and/or thoracic approach	
C70748	Sternal split for substernal thyroid; (extra)	

The following modification to the payment schedule has been approved, effective April 1, 2006:

CP07368	Laparoscopic splenectomy	$590.00 Anes.Level 6

Amendment

The cancellation date of the following provisional item has been extended until November 30, 2008, or when replaced by a subsequent Minute, whichever occurs first:

P07479	Sentinel lymph node biopsy (SLN) *Notes:* i) *Payable only for the staging of malignant breast disease and malignant melanoma.* ii) *Subsequent surgery (07474 or 07475) performed under same anesthetic is payable at 50% of the applicable fee of the lesser item.* iii) *Payable only to BCCA validated physicians.* iv) *SLN component of the combined procedures not payable to surgeons during the training phase.*	$433.96 Anes.Level 3

Vascular Surgery

Amendment

The following anesthetic intensity and complexity levels for the indicated Vascular Surgery fee items are hereby amended as follows:

		Anes.Level
Bypass graft (autogenous vein)		
77280 – non-ipsilateral long saphenous graft; extra	$228.32	7
77285 – short saphenous graft; extra	$228.32	7
77290 – superficial femoral vein graft; extra	$228.32	7
77295 – arm vein graft; extra	$228.32	7
77300 – A-V fistula with bypass graft in limb Salvage; extra	$166.38	7

Cardiac Surgery

The following items have been approved on a provisional basis, this will expire on October 31, 2008 or when replaced by a subsequent Minute.

New Fee Items

			Anes.Level
P78041	Laser Lead Extraction after 30 days, first lead Notes: *i)* Not payable with 07845, 00330, 00357. *ii)* Includes any and all diagnostic imaging related to the surgery.	$1331.92	9

iii) Claims for surgical assistance for laser lead extraction are payable under 00197.

P78042	Laser Lead Extraction after 30 days, additional leads, to a maximum of two – extra	$500.00	9
P78043	Debridement of chest wall during laser lead extraction – extra (payable only with 78041)	$50.00	9
P78044	Wide debridement of chest walls during laser lead extraction – extra (payable only with 78041)	$100.00	9

Thoracic Surgery

P79210	Telehealth Consultation: To include complete history and physical examination, review of X-ray and laboratory findings, and a written report	$114.41
P79212	Telehealth Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	$51.49
P79207	Telehealth subsequent office visit	$22.83
P79208	Telehealth subsequent hospital visit	$19.48

Radiology

Amendment

The cancellation date of the following provisional item has been extended until November 30, 2008:

P83000 Interventional Radiology Consultation – to include pertinent patient history, regional physical examination, review of laboratory and radiological findings and generation of a written report $75.00

Notes:

i) Payable only to physicians with appropriate training in interventional radiology.

ii) *Payable only when rendered in acute care public facilities.*

iii) *Must be initiated by written request by another physician.*

iv) *Payable only when interventional radiological procedure requires extensive discussion and review of all available data.*

v) *Includes all patient visits necessary.*

vi) *Payable only when patient is recommended for one of the following interventional therapeutic radiological procedure,* ***regardless if procedure is performed or is scheduled and subsequently cancelled****:*

- *a)* *Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery (10901)*
- *b)* *Varicocele and/or uterine artery embolization – unilateral/bilateral (00921/00925)*
- *c)* *Percutaneous image-guided tumor ablation (10908)*
- *d)* *Percutaneous transcatheter arterial chemoenmbolization (TACE) (10904)*

vii) *Payable if one of the following procedures is planned but cancelled subsequent to the consultation:*

a) *Percutaneous nephrostomy (00978)*
b) *Percutaneous nephrostomy with dilation of tract (00979)*
c) *Transhepatic biliary drainage procedure (00980)*
d) *Therapeutic radiological embolization (00981)*
e) *Percutaneous transluminal angioplasty (00982)*
f) *Percutaneous abdominal abscess drainage by catheter insertion (00983)*
g) *Embolization fee codes T00995, T00997, T00998*
h) *Abdominal aortic endovascular aneurysm repair using endovascular stent graft –radiology component (P10900)*
i) *Complex diagnostic neuroangiography*
j) *Percutaneous hemodialysis graft thromobolysis (P10903)*
k) *Cerebral intra-arterial thrombolysis (P10905)*
l) *Percutaneous intravascular/intracorporeal medical device/foreign body removal (P10909)*
m) *Selective salpingography/Fallopian tube recanalization (P10911)*
n) *Transjugular liver or renal biopsy (P10912)*
o) *Image-guided percutaneous vertebroplasty (P10906)*

viii) *Repeat consultation not applicable for same condition, same patient within six months.*

Amendment

The cancellation date of the following provisional items has been extended until November 30, 2008:

T10900 Abdominal aortic aneurysm repair using endovascular stent graft – radiology component $850.00

Notes:

i) Intraoperative renal artery angioplasty payable in addition at 50% of fee item 00982 when done.

ii) ***An Interventional Radiology Consultation is not payable unless the procedure is cancelled.***

P10901 Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery Anes.Level 2 $525.00

Notes:

i) Includes any medically necessary angiographies , any necessary imaging, all necessary catheter repositioning and ongoing assessment and care throughout the patient's active treatment phase.

ii) Payable at 100% for the first 12 hours of care and 50% for each additional 12 hours of care, up to 36 hours.

P10902 Peripherally inserted image-guided central venous catheter line (PICC) Anes.Level 2 100.00

Notes:

i) Interventional Radiology consultation not payable in addition, regardless of when rendered.

ii) Not applicable if performed via other than peripheral access.

iii) Includes placement, venogram/angiogram and all medically required image guidance.

iv) May not be delegated.

P10903 Percutaneous hemodialysis graft thrombolysis Anes.Level 2 $525.00

Notes:

i) *Includes declotting and treatment of underlying cause of access failure*

ii) *Includes angioplasty and all necessary imaging and intervention*

iii) ***An Interventional Radiology Consultation is not payable unless the procedure is cancelled.***

P10904 Percutaneous transcatheter arterial chemo-embolization (TACE) Anes. Level 3 $525.00

Notes:

i) *Fee is per session/sitting regardless of number of lesions treated;*

ii) *Includes all associated imaging necessary to complete procedure;*

iii) *Interventional Radiology consultation is payable.*

P10905 Cerebral intra-arterial thrombolysis Anes.Level 5 $1168.24

Notes:

iv) *Payable once only, regardless of number of arterial territories treated*

v) *Includes all diagnostic and superselective angiograms performed during procedure and immediate post procedure CT scans*

vi) ***An Interventional Radiology Consultation is not payable unless the procedure is cancelled.***

P10906 Image-guided percutaneous vertebroplasty-first level $325.00 Anes. Level 4

P10907 –each additional level (to a maximum of 3) $75.00 Anes..Level 4

Notes:

i) *Payable only when rendered on in-patient or day-care basis in acute care facility*

ii) *Payable for osteoporotic fractures only if conservative therapy shows no or minimal improvement after 4-6 weeks and pain remains incapacitating*

iii) *Includes all associated diagnostic imaging, including post-procedural CT scan necessary to complete the procedure*

iv) ***An Interventional Radiology Consultation is not payable unless the procedure is cancelled.***

P10908 Percutaneous image-guided tumour ablation – first lesion $432.00 Anes.Level 3

Notes:

i) *Payable only for non-resectable liver, kidney, lung tumours, colorectal metastases and osteoid osteoma;*

ii) *Payable to a maximum of 3 lesions treated at same session – 100% for first lesion, 75% for second lesion and 25% for third lesion;*

iii) *Includes all CT and ultrasound guidance necessary to complete the procedure;*

iv) *Paid at 50% if repeated within 30 days;*

v) *Interventional Radiology consultation is payable.*

P10909	Percutaneous intravascular/intracorporeal medical device/foreign body removal	$350.00 Anes.Level 3

Notes:

vi) *All angiography, angioplasty and/or intravascular stenting included.*

vii) *If a second or third medical device/foreign body is removed, payable at 50% each, to a total maximum of three.*

viii) ***An Interventional Radiology Consultation is not payable unless the procedure is cancelled.***

P10911	Selective salpingography/fallopian tube recanalization (FTR)	$350.00 Anes.Level 2

Notes:

i) *Hysterosalpingogram not payable in conjunction with the procedure*

ii) *Paid at 2/3 of the fee if unilateral*

iii) *FTR is not an insured benefit when used to correct scarring of the fallopian tubes after reversal of tubal ligation*

iv) *Any Imaging related to the procedure is inclusive*

v) ***An Interventional Radiology Consultation is not payable unless the procedure is cancelled.***

P10912	Transjugular liver/renal biopsy	$350.00 Anes.Level 2

Notes:

i) *Ultrasound guidance, venous puncture, central access catheter are included in the fee*

ii) *Payable only for uncorrectable coagulopathy*

iii) *The first biopsy is payable at 100%, the second and third at 50% up to a maximum of three per patient per day.*

iv) *If repeated within 6 months, payable at 50%*

v) ***An Interventional Radiology Consultation is not payable unless the procedure is cancelled.***

Laboratory Medicine

Amendment

The cancellation date of the following provisional item has been extended and will expire on June 30, 2007 or when replaced by a subsequent Minute, whichever occurs first:

P92355	Troponin	$30.77
P92510	Methadone Metabolite	$4.33
P92513	Methadone	$4.33
P92525*	Blood Methadone	$56.73
P91760***	Helicobacter pylori Carbon 13 urea breath test	$59.99
P91719	Glucose – 2 hr, post-75 g	$19.76
P92227	Sirolimus	$53.19

Amendment

The following note is added to the following fee item:

90315	Latex test (rheumatoid factor) Note: Also payable for immunoassay techniques for the detection and quantification of rheumatoid factor.	$11.49

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective March 1, 2007. As the effective date previously agreed to between the parties is February 1, 2007, a retroactive adjustment to laboratories, vested interest laboratories and hospitals will be made for dates of service between February 1, 2007 and February 28, 2007:

Amendment

The current note and fee items listed under the heading "Laboratory Procedures Short List" are replaced with the following:

The following tests are restricted to laboratories, vested interest laboratories and hospitals:

90000	Venepuncture and dispatch of specimen to laboratory, when no other blood work performed *Notes:* *i) This is the only fee applicable for taking blood specimens and is to apply in those situations where a single bloodwork service is provided by an unassociated facility or person* *ii) Where a blood specimen is taken by a laboratory and dispatched to another unassociated laboratory, the original laboratory may charge 90000 only when it does not perform another laboratory procedure using blood collected at the same time. (See Preamble Clause B.6.)*	$4.63
90640	Candida Culture	$6.50
90115	Examination for eosinophils in secretions, excretions and other body fluids	$51.55
P90795	Examination for pinworm ova	$41.89
90670	Fungus, direct examination, KOH preparation	$13.11
91700	Glucose - semiquantitative (dipstick analysed visually or by reflectance meter)	$3.33
90225	Haemoglobin cyanmethaemoglobin method and/or haematocrit	$3.07
90235	Haemoglobin - other methods ***Note**: 90225 and 90235 - see Laboratory Medicine Preamble for hematology protocol.*	$1.45
92005	Occult blood – faeces	$6.92
92108	Pregnancy test, immunologic - urine	$14.77
90512	Secretion smear for eosinophils	$6.97
90515	Sedimentation rate	$10.12
93170	Sperm, Seminal examination for presence or absence	$25.72
P90740	Stained smear	$15.93
P90785	Trichomonas and/or Candida, direct examination	$11.09
92385	Urinalysis - Chemical or any part of (screening)	$1.96
92391	Urinalysis - Microscopic examination of centrifuged deposit	$4.00
92382	Urinalysis - Complete diagnostic, semi-quant and micro	$5.37

90570	White cell count only (see hematology protocol)	$9.49

The following tests, when performed in physicians' offices, are accepted for payment by the Medical Services Plan of British Columbia and will be listed in the appropriate Section. These tests are not payable to laboratories, vested interest laboratories and/or hospitals:

00012 Venepuncture and dispatch of specimen to laboratory, when no other blood work performed $4.63

Notes:

i. This is the only fee applicable for taking blood specimens and is to apply in those situations where a single bloodwork service is provided by an unassociated facility or person.

ii. Where a blood specimen is taken by a physician's office and dispatched to another unassociated physician's office or diagnostic facility, the other physician's office may charge 00012 only when it does not perform another laboratory procedure using blood collected at the same time. (See Preamble Clause B.6.)

iii. When billed with another service such as an office visit, 00012 may be billed at 100%.

15132	Candida Culture	6.50
15133	Examination for eosinophils in secretions, excretions and other body fluids	6.97
P15134	Examination for pinworm ova	5.76
04699	Fern Test	5.48
15136	Fungus, direct examination, KOH preparation	8.23
15100	Glucose - semiquantitative (dipstick analysed visually or reflectance meter)	3.33
15137	Haemoglobin cyanmethaemoglobin method and/or haematocrit	3.07
15000	Haemoglobin - other methods	1.45

Note: 15137 and 15000 - see Laboratory Medicine Preamble for hematology protocol.

15110	Occult blood - faeces	4.41
15120	Pregnancy test, immunologic - urine	9.85
00395	Secretion smear for eosinophils	7.07
15138	Sedimentation rate	2.46
15139	Sperm, Seminal examination for presence or absence	14.40
P15140	Stained smear	7.25
P15141	Trichomonas and/or Candida, direct examination	5.49
15130	Urinalysis - Chemical or any part of (screening)	1.96
15131	Urinalysis - Microscopic examination of centrifuged deposit	4.00
15142	Urinalysis - Complete diagnostic, semi-quant and micro	5.37
15143	White cell count only (see hematology protocol)	6.31

The following test is payable to laboratories, vested interest laboratories, hospitals and physician's offices:

93120	E.C.G. tracing, without interpretation	14.27

Amendment

The following amendments are effective February 1, 2007:

The note following fee item 90037 (Antiphosphatidylserine (IGM) stating *"When both P90036 and P90037 performed on same specimen, second test is billable at $22.38* is hereby deleted.

The note following fee item 90039 (Anti Saccharomyces Cerevisiae (ASCA) IgG) stating *"When both P90038 and P90039 are performed on same specimen, second test is billable at $25.11* is hereby deleted.

The following note pertaining to ***Generic Listings Split (91830, 92040 & 91945)*** is hereby amended as indicated:

a) The following new listings have been split from the listing for Immunoglobulin and specific protein assays (91830): 90660, 90770, 91025, 91165, 91170, 91280, 91445, 91450, 91810, 91811, 91812, 91813, 91814, 91825, 91835, 91936, 92105, 92205, 92290, 92340 and 92345.

Note: Additional assays, same patient, same day, to be billed under the correct pertinent fee code but will be paid as previously, at the rate for 91831.

The following fee items have been removed from the above note and are payable in full when additional assays for same patient, same day are performed:

91285	C - 3 complement
91290	C - 4 complement
91300	C – reactive protein
91305	CA 15-3
91310	CA 125
91315	CA 19-9
91802	IgA quantitative – serum/plasma
91840	IgA - quantitative
91845	IgA - quantitative
91985	Micro albumin

The payment rates of the following fee items are hereby adjusted as indicated, effective February 1, 2007. A retroactive adjustment will be done for claims with dates of service from February 1, 2007 that have been paid at a lower rate.

90770***	Tetanus antibodies	$19.92
91170*	Apolipoprotein B-100	$19.23
92345	Transferrin	$19.02
91280	C - 1q esterase inhibitors	$21.80
91811	IgG^2	$21.80
91812	IgG^3	$21.80
91813	IgG^4	$21.80

Amendment

The provisional status ("P") of the following items is hereby removed:

	Haematology:	**Total Fee $**
90027***	Activated Protein C Resistance (APCR)	39.99
90036**	Antiphosphatidylserine (IgG)	23.15
90037**	Antiphosphatidylserine (IgM)	17.49
90038***	Anti Saccharomyces Cerevisiae (ASCA) – IgA	24.28
90039***	Anti Saccharomyces Cerevisiae (ASCA) – IgG	19.60
90042***	Anti-Xa Heparin assay	88.67
90045**	Bone marrow examination	212.78
	***Note**: 90045 includes 90465, 90490, 90205, 90340 and 90210.*	

90055***	Circulating inhibitor screen - unincubated simple mixing study	28.77
90065	Cold agglutinins – qualitative	13.64
90072**	Collagen Binding assay	49.47
	Note: Not billable with 90505.	
90073**	Dilute Russell Viper Venom Time	13.19
90075**	Differential cell count on body fluids other than blood	9.81
90080	Direct antiglobulin (Coombs') test, polyspecific	23.41
90095**	Erythropoietin (EPO) assay	27.81
90127***	Factor V Leiden / PGM – 1st gene	73.33
	Notes:	
	i) Restricted to Royal Columbian, Vancouver and Victoria General Hospitals	
	ii) Not billable for screening purposes	
	iii) Applicable to patients with thrombophilia.	
90128***	Factor V Leiden / PGM – 2nd gene	46.26
	Notes:	
	i) Billable only when performed with T90127	
	ii) Restricted to Royal Columbian, Vancouver and Victoria General Hospitals.	
90185	Glucose-6-phosphate dehydrogenase (G-6-PD) screening test	40.90
90240**	Haemoglobin electrophoresis	28.11
90290**	Immunophenotyping by flow cytometry - peripheral blood and/or tissue and/or bone marrow and/or body fluids - 5 tube panel	212.98
90335**	Malaria and other parasites	58.93
90340**	Marrow films for interpretation	156.13
90357	Neutrophil Oxidative Burst Assay	106.25
90360**	Nitro blue tetrazolium test	28.69
90377**	Phospholipid Neutralization Test – for confirmation of Lupus Anticoagulant	40.28
90390**	Platelet antibodies	32.47
90400	Platelet estimation on film	4.37
90427**	Protein S Activity (clot-based)	36.10
	Note: *Not billable with 90435 or 90430*	
90440	Prothrombin time/INR	10.68
90460+	RBC antibody detection, per tube (albumin, enzyme or other antibody enhancement, e.g. LISS additive)	6.50
90465	RBC morphology including platelet estimation	16.53
90470	Red cell folate	30.64
90510+	Saline tubes (per tube)	7.15
90525	Sickle cell identification	71.99
90530***	Stypven prothrombin time	26.65
90560***	Von Willebrand's multimer analysis by autoradiography	83.64
91160**	Antimyeloperoxidase Ab	42.66
91355	Cells, count - CSF and other fluids	27.42

Microbiology:

90605**	Anaerobic culture investigation	11.22
90610***	Smear for inclusion bodies	62.57
90615**	Antibiotic susceptibility test, semi-quantitative per organism	11.07
90620	Biochemical identification of micro-organism- per organism	9.10
90625**	Blood culture, using aerobic and/or anaerobic media	34.39
90651	Chlamydia trachomatis using NAT – urine	24.00

90652	Chlamydia trachomatis using NAT – urogenital swab	22.96
90665**	Fungus culture	20.40
90730	Smear for inclusion bodies	11.67
90740	Stained smear	15.93
90750	Biochemical identification of micro-organism in stool	13.76
90780**	Throat or nose culture - each additional culture	17.34
90785	Trichomonas and/or candida, direct examination	11.09
90795	Examination for pinworm ova	41.89
90815	Serological tests - 1 to 3 antigens	34.70
90820	Serological tests - 4 or more antigens	35.78
	Note: Not to be billed for any virology testing where specific listings exist (e.g.: Hepatitis).	
90825***	Smear or section for electron microscopy	26.19
90830	Virus isolation	44.57

Chemistry:

91023**	Acetyl CoA: a-glucosaminide-N-acetyl transferase, white blood cells Note: Restricted to BC Children's Hospital.	88.29
91027**	Acid Lipase, white blood cells *Note: Restricted to BC Children's Hospital.*	48.29
91036***	ACTH stimulation test	42.62
91037**	Acylcarnitine profiling *Note: Restricted to BC Children's Hospital.*	38.89
91096**	Alpha-iduronidase, white blood cells *Note: Restricted to BC Children's Hospital.*	48.29
91097**	Alpha-mannosidase, white blood cells *Note: Restricted to BC Children's Hospital.*	48.29
91120***	Amniotic fluid, bilirubin scan	51.91
91142**	Anti-diuretic hormone (ADH), plasma	107.22
91155*	Antiglomerular basement membrane antibody	24.53
91162	Anti-tissue transglutaminase antibodies (anti-TTG), IgA *Note: Not billable with 91800.*	23.05
91180***	Apoprotein E genotyping	88.46
91231**	Beta-glucuronidase, white blood cells *Note: Restricted to BC Children's Hospital.*	48.29
91232**	Beta-mannosidase, white blood cells *Note: Restricted to BC Children's Hospital.*	48.29
91330	Calculus analysis – urine	26.56
91380**	Cholinesterase with dibucaine number	28.52
91386***	Chromatography - keto acids	34.21
91387***	Chromatography - reducing substances-urine	29.58
91388***	Chromatography - thin layer (T.L.C.)	30.77
91395	Complement, total haemolytic (CH 100)	41.66
91480	Acetazolamide	43.99
91484	Amikacin	43.84
91486	Amiodarone	43.84
91490	Amoxapine	43.84
91492	Chlorpromazine	43.84

91496	Clobazam	46.85
91498	Clomipramine	46.94
91500	Clonazepam	43.84
91508	Desmethylclobazam	43.84
91510*	Diazepam	43.84
91512	Disopyramide	43.84
91514	Doxepin	43.84
91516	Fluoxetine	43.84
91518	Flupenthixol	43.84
91520	Fluphenazine	43.84
91522	Fluvoxamine	43.84
91526	Haloperidol	23.20
91528	Imipramine	43.84
91530	Lidocaine	42.14
91532*	Lorazepam	43.84
91534	Loxapine	43.84
91536	Maprotiline	43.84
91538	Methotrexate	43.84
91540	Methotrimeprazine	43.84
91542	Methylphenidate	43.84
91544	N-Acetyl procainamide	43.84
91546	Netilmicin	43.84
91548	Nitrazepam	43.84
91552	Paroxetine	43.84
91554	Perphenazine	43.84
91556	Procainamide	43.84
91558	Propranolol	43.84
91560*	Sertraline	49.32
91562	Thioridazine	45.67
91566	Trazodone	43.84
91568	Trifluoperazine	43.84
91570	Trimipramine	43.84
91601**	Electrophoresis - protein, quantitative	32.97
91602**	Electrophoresis - C.S.F	29.75
91680	Gastric analysis, intubation	17.10
91715***	Glucose quantitative, 2 to 5 hours	10.82
91717**	Glucose quantitative – intravenous	36.65
91730	Glutathione peroxidase	41.76
91762**	Heparan sulfamidase, white blood cells	88.29
	Note: Restricted to BC Children's Hospital.	
91777**	Hexosaminidase, white blood cells	93.55
	Note: Restricted to BC Children's Hospital.	
91800	IgA Anti-gliadin antibodies	30.70
	Note: Applicable only to TTG negative gluten sensitive enteropathy.	
91820***	Immunofixation – CSF	99.23
91850	Inclusion bodies - (cytomegalic) – urine	7.33
91912	Lead - prophyrin screening test – urine	5.86
91915***	Lecithin sphingomyelin ratio	218.82
91920***	LHRH stimulation test - in addition to specific tests billed	43.54
91940**	Lipoprotein electrophoresis	52.80
91970	Metachromatic granules – urine	15.19
91992	Mitochondrial preparation – muscle	85.32
	Note: Restricted to BC Children's Hospital.	

91997**	N-acetyl-Galactosamine-6-sulfate sulfatase, white blood cells *Note: Restricted to BC Children's Hospital.*	88.29
92035	Pentagastrin test – gastric	63.60
92075	Pigments, abnormal, (spectroscopic)	13.24
92090	Porphyrins - qualitative, urine	7.27
92091	Porphyrins - quantitative with separation – urine	54.10
92095**	Porphyrins - quantitative – blood	20.75
92110	Pregnancy Test – Serum	14.05
92146	Proteins - timed urine collection	5.68
92156**	Pyruvate Carboxylase, Fibroblasts *Note: Restricted to BC Children's Hospital.*	88.29
92157**	Pyruvate Dehydrogenase, fibroblasts *Note: Restricted to BC Children's Hospital.*	88.29
92195**	Respiratory chain enzymes – muscle *Notes:* *i) Includes Complex 1, Complex II, Complex IV, citrate synthase* *ii) Restricted to BC Children's Hospital.*	258.67
92201	Salicylates, qualitative – gastric	2.73
92202	Salicylates, qualitative – urine	2.83
92320***	Thyroid Releasing Hormone (TRH) Stimulation Test *Note: Includes all time spent with patient, including injection and medication administered.*	52.67
92346**	Transferrin Isoelectric focusing (qualitative) *Note: Restricted to BC Children's Hospital.*	85.26
92353**	13C Triolein Breath Test for malabsorption *Notes:* *i) Includes collection of "before" and "after" breath samples.* *ii) Not billable with 91636.*	63.97
92395	Urinalysis, microscopic	6.82
92430*	Vitamin A	45.10
92435*	Vitamin B1	51.16
92440*	Vitamin B2	51.16
92445*	Vitamin B6	51.16
92465	Vitamin E	50.82
92467	White blood cell preparation for lysosomal enzyme testing *Note: Restricted to BC Children's Hospital.*	39.91
92470**	Xylose tolerance	100.01
	Anatomical:	
93010	Crystal identification, synovial fluid	38.18
93070***	Chromosomal breakage studies	171.28
93085	Cytologic preparation and examination of fine needle aspirate	89.84
93090	Cytologic preparation and interpretation of pre-screened, non-gynaecological cytology	62.48
93095	Cytologic preparation and interpretation of unscreened, non-gynaecological cytology	81.52
93100*	Electron microscopy fee	366.45

Nuclear Medicine:

09817	Receptor Imaging - Isolated Procedure	235.77
09826	Tumour imaging - isolated procedure	1265.13
09870	Ocular tumour localization	164.92
09871	Brain scan - regional cerebral blood flow (isolated procedure)	239.95
09880	Treatment for hyperthyroidism or cardiac disease - charge per course of treatment (Iodine therapy)	205.41
09881	Treatment for polycythaemia vera with P32 - charge per course of treatment	205.41
09883	Treatment for prostate cancer - charge per course of treatment	414.88
09884	Treatment for metastatic carcinoma of bone - charge per course of treatment	269.74
09885	Treatment for ascites and/or pleural effusion, malignant	403.91
09898	Coronary perfusion with radio particles, per radionuclide	175.74

Medical Microbiology:

94005	Emergency visit when specially called (not paid in addition to out-of- office-hours premiums)	$104.76
94010	Consultation: to consist of examination, review of history and laboratory findings with a written report	$117.83
94012	Repeat or limited consultation: where a consultation for same illness is repeated within six (6) months of the last visit by the consultant or where, in the judgement of the consultant, the consultative service does not warrant a full consultative fee	$65.47
94006	Directive care	$26.19
94007	Subsequent office visit	$26.19
94008	Subsequent hospital visit	$26.19
94009	Subsequent home visit	$52.43

The following fee items are added under the Chemistry subsection, effective May 1, 2007:

91353	Cells count - examination for faeces	$5.14
91631	Fat, microscopic examination – faeces	$5.22

Amendment

Effective immediately, the following notes are added to the indicated fee items:

92108 Pregnancy test, immunologic urine

Notes:

i) Payable for pregnancy testing utilizing pregnancy test devices approved for professional use.

ii) Not payable for quantitative hCG testing utilizing automated test results.

92110 Pregnancy test – serum

Notes:

i) Payable for pregnancy testing utilizing pregnancy test devices approved for professional use.

ii) Not payable for quantitative hCG testing utilizing automated test results.

PharmaNet Information Proves a Valuable Tool for Enhancing Patient Care

Medical Practices Rate Access to PharmaNet Information

The Ministry of Health recently surveyed medical practices that have access to PharmaNet. The survey was designed to measure the value of Medical Practice Access to PharmaNet (MPAP) to these practices, to gauge the influence of PharmaNet information on patient care, and to capture users' comments and concerns.

Of the 504 medical practices that were using the service in June 2006, 161 responded.

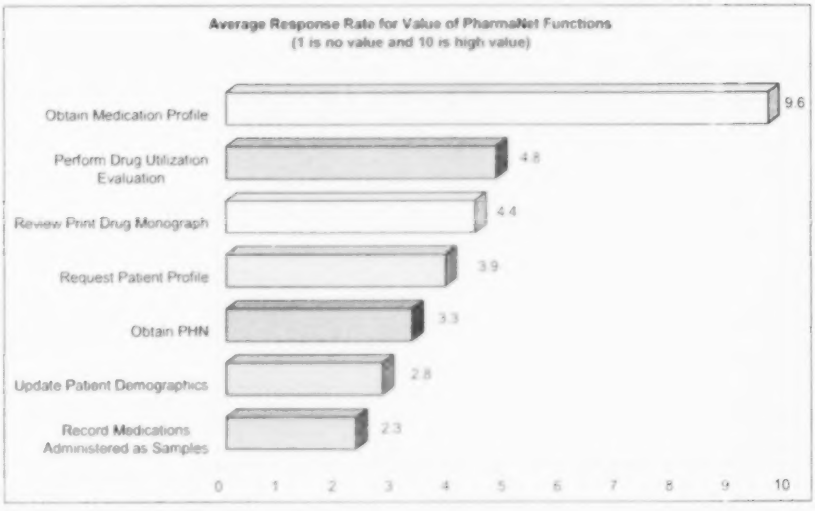
- Respondents estimated that, on average, the PharmaNet information affected medication and/or treatment decisions ..... **59% of the time**.
- Respondents also reported that PharmaNet information enhanced the accuracy and completeness of the patient's medication history ..... **75% of the time**.
- And, when asked to rate how well PharmaNet information met their expectations, respondents came in with an average rating of ..... **7.9 out of 10**.

How often were respondents accessing PharmaNet?

The survey results indicate that the longer a practice has access to PharmaNet, the more frequently they use it. Of the 37 respondents who have had access to PharmaNet for five months or more, 25 were using the service 21 to 30 times a day.

What were the most valued functions of MPAP?

As shown here, the survey indicated that the most valued functions were obtaining a patient's medication profile, performing a Drug Utilization Evaluation and reviewing drug monographs.



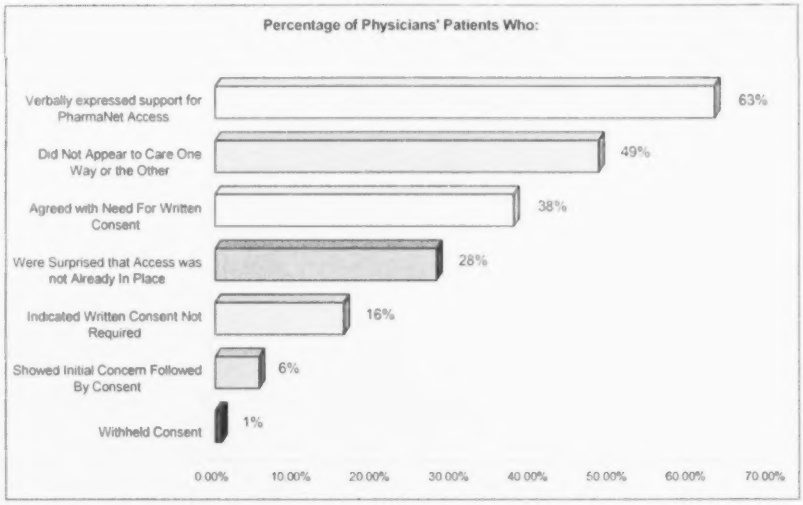
Was access to PharmaNet more likely under certain circumstances?

Yes. When we asked respondents to indicate all the situations in which they accessed PharmaNet, practices indicated they used PharmaNet access:

- when deemed necessary by a physician (84 practices)
- for suspected drug-seeking patients (69)
- for all new patients (48 practices)
- for returning patients for medical history (37)
- for new patients with communication barriers (36)
- for all returning patients (34)
- for returning patients with communication barriers (33)
- for new patients for medical history (31)

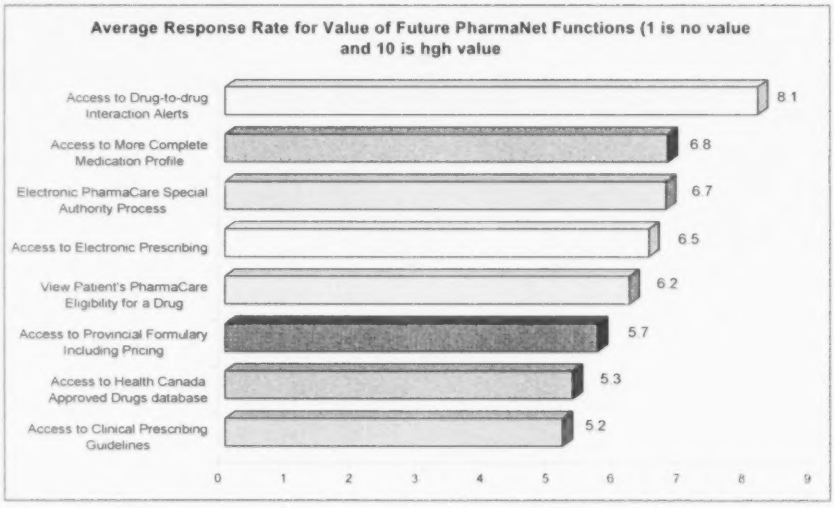
How are patients reacting to the MPAP service?

We asked the practices to estimate the proportion of patients indicating various levels of support for MPAP. Most practices indicated that the majority of patients (an average of 63%) supported their physician accessing PharmaNet. Very few patients chose to withhold the consent necessary for the practice to access their PharmaNet record.



Did respondents report difficulties that impeded use of the MPAP service?

A small number (40) of the 161 respondents indicated some concerns—primarily with the time required to explain PharmaNet access to patients. However, the vast majority of respondents did not indicate significant challenges in using the system.



Of the planned PharmaNet enhancements, which functions were valued most?

With a new improved PharmaNet system on the way, we asked respondents to identify the planned PharmaNet features they felt they would value most. As shown below, access to drug-to-drug interaction alerts was highest on the list.

Did respondents comment on other topics?

Within the survey, medical practices were invited to provide additional comments on their experience with the MPAP service. The comments indicated the usefulness of the service and provided valuable information on the improvements that medical practices would like to see such as: ✧ more thorough training ✧ expansion of access to satellite/remote clinics ✧ integration of the MPAP service with the Electronic Medical Record (EMR) systems in physician offices ✧ financial incentives for medical practices wanting to purchase hardware and software ✧ the ability to access PharmaNet without written patient consent.

Most survey respondents indicated that access to a patient's PharmaNet medication profile reduced the time involved in obtaining a medication history.

BRITISH COLUMBIA | Ministry of Health
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BRITISH COLUMBIA MEDICAL ASSOCIATION

NO CARDIOPULMONARY RESUSCITATION

Patients who know they have a terminal illness or who are considered at the natural end of their lives can request beforehand that no active resuscitation be started on their behalf if they are dying. This should be done after discussions with their doctor. "No active resuscitation" is defined as no cardiopulmonary resuscitation (no CPR) in the event of a respiratory and/or cardiac arrest.

This form is provided to you and/or your next of kin by your doctor to allow you to clearly state that you do not want active resuscitation to be given to you in circumstances where you can no longer make the decision for yourself. It instructs people such as ambulance attendants and emergency room personnel not to start active resuscitation on your behalf whether you are at home, in the community or in a long term care facility. The personal information collected on this form assists the health professionals noted above to carry out your wishes. If you have any questions about the collection of this information contact the **Ministry of Health at 250-952-1742 or toll-free at 1-800-465-4911.**

It is recommended that your doctor or alternate be called first to attend to your needs and not the BC Ambulance Service. You or your next of kin should have the form available to show to emergency help if they are called to come to your aid. It is desirable that you wear a no CPR bracelet to enable quick verification that you have a No CPR order in place.

If you change your wishes about this matter, then please inform your doctor and community nurse and tear up the form.

PATIENT IDENTIFICATION

SURNAME | BIRTHDATE (YY/MM/DD)

GIVEN NAMES

ADDRESS | PHONE NUMBER

SAMPLE

SIGNED BY THE PATIENT

I, _____ *(patient's name in full)* understand and accept that I have been diagnosed as having a terminal illness or am considered to be at the natural end of my life and that my care is to include support and comfort only and that no active resuscitation is to be undertaken. I hereby make the consent decision that in the event of a respiratory and/or cardiac arrest, no cardiopulmonary resuscitation is to be undertaken. This decision shall be in effect unless rescinded and should be reviewed in one year.

PATIENT'S SIGNATURE | DATE

SIGNED BY THE PATIENT'S AUTHORIZED SUBSTITUTE DECISION MAKER (ASDM)

(WHERE THE PATIENT IS INCAPABLE OF MAKING A CONSENT DECISION)

I, _____ , am the authorized substitute decision maker
(name of the patient's authorized substitute decision maker)

of _____ *(name of patient identified above)* and I understand and accept that care is to include support and comfort only and that no active resuscitation is to be undertaken. I hereby make the consent decision that in the event of a respiratory and/or cardiac arrest, no cardiopulmonary resuscitation is to be undertaken. This decision shall be in effect unless rescinded and should be reviewed in one year.

SIGNATURE OF THE PATIENT'S AUTHORIZED SUBSTITUTE DECISION MAKER | DATE | SIGNATURE OF WITNESS

RELATIONSHIP OF THE PATIENT'S AUTHORIZED SUBSTITUTE DECISION MAKER TO THE PATIENT
(e.g. representative, committee of person, or temporary substitute decision maker) | WITNESS (IN PRINT)

PHYSICIAN ONLY

PHYSICIAN'S NO CPR ORDER

- ☐ Patient (or ASDM) agrees and has signed this form
- ☐ Patient (or ASDM) agrees but has declined signing this form
- ☐ Patient (or ASDM) disagrees with my order and has declined signing this form

The above identified patient has been diagnosed as having a terminal illness, or is considered to be near the natural end of their life. I have discussed the prognosis of this illness, the life expectancy, the person's wishes and the treatment options with the patient/patient's authorized substitute decision maker. Based on this discussion, I order that in the event of a respiratory and/or cardiac arrest no cardiopulmonary resuscitation is to be undertaken. This order shall be in effect unless rescinded and should be reviewed in one year.

ATTENDING PHYSICIAN'S NAME (IN PRINT) | ALTERNATE PHYSICIAN'S NAME (IN PRINT)

ATTENDING PHYSICIAN'S ADDRESS | PHONE NUMBER | ALTERNATE PHYSICIAN'S PHONE NUMBER

ATTENDING PHYSICIAN'S SIGNATURE | DATE

WHITE COPY – TO PATIENT **YELLOW COPY** – TO ATTENDING PHYSICIAN **PINK COPY** – COMMUNITY HOME CARE NURSING SERVICES *(IF PATIENT IN CARE)*

HLTH 922.1 Rev. 2007/03/05
Developed in conjunction with the BCMA

Form may be ordered by sending a fax to: Product Distribution Services Customer Service, Fax 250-952-4412

PATIENT/FAMILY INSTRUCTIONS

Just looking at this form may be one of the most difficult things you have ever done. Many thoughts and emotions may surface. So often people try to ignore their mortality, yet we all know it is one of the facts of life: we all, one day, will die.

The purpose of this document is not to tell you when you will die. This document is offered to you because the disease/condition with which you are faced is a life-threatening one. It is hoped this form will encourage you to express your wishes about what you would like to have happen in the event you stop breathing or your heart stops beating. Take time to thoughtfully consider this document and to ask your health care professionals what resuscitation would entail and any risks to quality and/or quantity of life that might accompany resuscitation of a person in your condition.

When your choice is to die at home, you will need to make additional plans. The steps you will need to consider in your plan are listed below.

If you are a family member who is asked to consider this document on behalf of your loved one, all of what is said above applies also. This can be a stressful decision. Remember to seek support from trusted family members, friends and/or your spiritual advisor.

INDIVIDUAL / FAMILY

What to Do Ahead of Time

- Discuss option of an in-home death with your physician.
- Make a plan with your family physician so you are clear about what will happen and family/friends will know what to do at the time of death. Your plan will need to include:
  - who will pronounce death;
  - how your physician can be reached;
  - what alternate arrangements have been made should your physician be unavailable or cannot be reached;
  - which funeral home will be called to transport the deceased.
- Make prearrangements with a funeral home. Such arrangements will normally involve selecting the funeral home and making plans with the funeral director for transportation of the deceased after death and the method of final disposition. For information on funeral homes in your area, you could contact the B.C. Funeral Association at 1-800-665-3899.
- Communicate in writing your plan to family, friends, and others such as your spiritual advisor so they may support your decisions and respect your wishes.
- Ensure that the original copy of this form is easily available in your home. If you and your dying relative/friend are away from your home for any reason, take the form with you so it may be should it be necessary.

FAMILY / FRIENDS

What to Do at the Time of Death

- DO NOT CALL 911, the ambulance, coroner, police, or fire department.
- CALL family, friends, and the spiritual advisor you would like to have present.
- CALL the physician to pronounce death.
  - If your physician cannot be reached, CALL the backup physician or registered nurse if prearranged;
- CALL the funeral home when you are ready....There is no rush to call if you wish to take extra time.

People to Call	Name	Telephone Number
Physician		
Alternate Physician		
Registered Nurse		
Funeral Home		
Spiritual Advisor		
Home Support Agency		
Hospice Program		
Family and Friends		

There are communities in British Columbia without physicians who live in the community and without a funeral home. It is essential that these situations be discussed by the patient, family and physician and an appropriate plan suitable for the community be made in advance.

MedicAlert

No CPR MedicAlert® Bracelets for British Columbians

Since 1961, Canadian MedicAlert Foundation has been saving lives by providing immediate access to personal and medical information in emergencies. In recent years, medical information has for some individuals come to include a "No CardioPulmonary Resuscitation" (No CPR) order, also known as "Do Not Resuscitate" (DNR) order signed by a physician.

In British Columbia, (as well as in many other jurisdictions) No CPR orders may be written on a prescribed Ministry of Health form by a physician for patients who:

- have been diagnosed as having a terminal illness or are considered to be at the natural end of their life, **and**
- who have made the decision that in the event of a respiratory and/or cardiac arrest, no cardio-pulmonary resuscitation is to be undertaken.

The British Columbia Ministry of Health's No CPR form has been developed in cooperation with the British Columbia Medical Association (BCMA). Past experience has shown that a person's signed No CPR form cannot always be readily located in an emergency situation.

The Ministry of Health and the BCMA have agreed to recognize the MedicAlert No CPR bracelet as an extension of the signed No CPR form in order to ensure that, to the greatest extent possible, an individual's right to make their own consent decisions regarding No CPR are respected.

To help your patients register with MedicAlert, **please use this fax-back form to order brochures** and display them in your clinic. Only those British Columbians whose physician has signed a No CPR Form for them are eligible to order a No CPR bracelet from MedicAlert.

How Do I Get MedicAlert® No CPR Enrollment Forms?

Fax toll-free to Canadian MedicAlert Foundation 1-800-392-8422

Please send me free of charge:

○ MedicAlert No CPR brochures Quantity _____

○ MedicAlert registration brochures Quantity _____

○ Display stand for brochures

I have ordered brochures from MedicAlert before ☐ YES ☐ NO

Name: _____

Clinic / office: _____

Address: _____

City: _____

Province: _____ **Postal Code:** _____-_____

Phone: _____ **Fax:** _____

E-mail: _____

For more information on the No CPR Program at MedicAlert call 1-800-668-1507, ext. 1229

BRITISH COLUMBIA
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COMPLEX CARE FEES

Introduction:

The intent of the complex care fees is to compensate General Practitioners for the extra time required to provide planned care to more complex patients that are residing in their homes or in assisted living (excludes care facilities). Under Option 1, they can be billed to a **maximum of six times** per calendar year (January to December). Under Option 2 there is only one billing for all care provided over the balance of the calendar year for the 2 conditions covered regardless of the number of visits this may require (i.e. pre-paid for all care for the complex conditions).

These items are **payable only to the General Practitioner or practice group** that accepts the role of being most responsible for the longitudinal, coordinated care of that patient. By billing this fee the practitioner or practice accepts this responsibility for the ensuing calendar year.

The General Practitioner or practice group may bill these fees when providing care to patients residing in their homes or in assisted living with **any two** of the following chronic conditions:

- Diabetes mellitus (type 1 and 2)
- Chronic renal failure with eGFR values less than 60
- Congestive heart failure
- Asthma
- Chronic obstructive pulmonary disease (emphysema and chronic bronchitis)
- Cerebrovascular disease
- Ischemic heart disease, excluding the acute phase of myocardial infarct

*Diagnostic codes have been developed to cover all combinations of any two of the following conditions - **refer to Table 1** (page 5).

How to Bill:

There are two billing options for the complex care fees. Each option pays a maximum of $315 per calendar year (January to December) for the complex care provided. Under Option One, visit fees are billed in addition to the complex care fees to a maximum of six visits per calendar year. Under Option 2 there is only one billing for all care provided over the balance of the calendar year for the 2 conditions covered regardless of the number of visits this may require.

The difference is that under one option you are paid as you provide the complex care service. Under the other option, you are paid the total amount in advance for providing the complex care.

Please note that these fees are not payable to physicians who:

- have been paid for any specialty consultation fee in the previous 12 months

- are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care
- are working under salary, service contract or sessional arrangements.

You may choose one of two ways to bill for the complex care fees:

Option 1 – bill as you provide the complex care
Option 2 – receive a lump sum payment in advance of providing the complex care

Once a billing option is chosen for each patient, you may not change to the other payment option for that individual patient until the next calendar year.

OPTION 1

- Services provided under this option follow the standard fee-for-service model and require the physician to have face-to-face contact with the patient each of the six times the complex care fee is billed
- Each of the complex care fees is payable in addition to an office visit, home visit, or complete physical examination
- A billing for an office visit, home visit, or complete physical examination must occur on the same day that the complex care fee is billed
- The total amount payable under the following fee items is the same as the payment for complexity under Option 2 below
- Use ICD9 codes listed in Table 1

Billing Summary

Option 1 – billing per visit (max six visits/calendar year)

Complex care fees:

1 x G14030 – Major Complex Care Plan	$100
1 x G14031 – Minor Complex Care Plan	$75
4 x G14032 – Complex Care Follow-up (4 x $35)	$140
Total	**$315**

- all six visits **must** be conducted in person by a GP and be accompanied by a visit billing

Visit fees – in office:

Bill for each visit in addition to the appropriate complex care fee G14030/G14031/G14032:

00100	Visit – in office (age 2-59)	$27.90
16100	Visit – in office (age 60-69)	$32.08
17100	Visit – in office (age 70-79)	$34.87
18100	Visit – in office (age 80+)	$36.27

Under both Option 1 and 2:

- CDM fees G14050/G14051 are payable on the same day for the same patient if all other criteria are met
- Community conferencing fee G14016 payable on the same day for the same patient if all other criteria are met
- for complex patients who live at home or in an assisted-living facility (excluding long-term care facilities)

1. Create a major complex care plan in your first complex care fee visit - G14030- Major Complex Care Plan - $100

The initial service allowing access to the complex care fees shall be the development of a Complex Care Plan for a patient residing in their home or assisted living (excludes care facilities) with two or more of the above chronic conditions. This requires documentation in the patient's chart that there has been a detailed review of the case/chart and of current therapies and a face-to-face visit with the patient or the patient's medical representative.

From those two activities a Complex Care Plan for that patient will be developed that:

- specifies a plan for that patient's care
- incorporates the patient's values and personal health goals
- outlines expected outcomes
- outlines linkages with other health care professionals that would be involved in the care, and their expected roles and an appropriate time frame for re-evaluation of the plan
- is recorded in the patient's chart
- is communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved health professionals as indicated.

Notes:

i) Payable once per calendar year
ii) Payable in addition to a visit fee billed same day
iii) Visit fee to indicate face-to-face interaction with patient same day must accompany billing
iv) Not payable on same day as G14031, G14032 on same patient
v) Not payable in the same calendar year as G14033, 13135, 13136, 13137 or 13138
vi) G14016, community conferencing fee payable on same day for same patient, if all criteria met
vii) CDM fees G14050/G14051 payable on same day for same patient, if all other criteria met

2. Create a minor complex care plan - G14031-Minor Complex Care Plan - $75

During one of the remaining five visits, a significant review of the major complex care plan is necessary, and is referred to as the minor complex care plan.

Notes:

i) Not payable unless the Major Complex Care Plan has been previously billed in the same calendar year
ii) Payable once per calendar year

iii) Payable in addition to a visit fee billed same day
iv) Visit fee to indicate face-to-face interaction with patient same day must accompany billing
v) Not payable on same day as G14030, G14032 on same patient
vi) Not payable in same calendar year as G14033, 13135, 13136,13137 or 13138
vii) G14016, community conferencing fee payable on same day for same patient, if all criteria met
viii) CDM fees G14050/G14051 payable on same day for same patient, if all other criteria met

3. Follow-up visits - G14032-Complex Care Follow-up - $35 x 4 = $140

Four of the six visits are considered follow-up and are worth $35 per visit for a total of $140. This fee is payable upon review of an eligible patient's clinical status with minor review of the Complex Care Plan.

Notes:

i) Payable a maximum of 4 times per calendar year
ii) Not payable unless the Major Complex Care Plan has been previously billed in the same calendar year
iii) Payable in addition to a visit fee billed same day
iv) Visit fee to indicate face-to-face interaction with patient same day must accompany billing
v) Not payable on same day as G14030, G14031 on same patient
vi) Not payable in same calendar year as G14033, 13135, 13136, 13137 or 13138
vii) G14016, community conferencing fee payable on same day for same patient, if all criteria met
viii) CDM fees G14050/G14051 payable on same day for same patient, if all other criteria met

4. Use the age-related visit fees

Use the age appropriate fee for the patient at each visit. Option One does not allow block funding for the care, but is billed at each visit with the complex care fee.

00100	Visit – in office (age 2-59)	$27.90
16100	Visit – in office (age 60-69)	$32.08
17100	Visit – in office (age 70-79)	$34.87
18100	Visit – in office (age 80+)	$36.27

5. Use the ICD9 codes listed in Table 1 (next page)

Diagnostic codes have been developed to cover all combinations of any two of the chronic conditions covered under the complex care fees as described earlier.

Table 1

ICD9 Code	Condition One	Condition Two
A414	Asthma	Ischemic Heart Disease
A428	Asthma	Congestive Heart Failure
A250	Asthma	Diabetes
A430	Asthma	Cerebrovascular Disease
A585	Asthma	Chronic Kidney Disease (Renal Failure)
A491	Asthma	COPD (with Emphysema, Chronic Bronchitis)
I428	Ischemic Heart Disease	Congestive Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease (Renal Failure)
I491	Ischemic Heart Disease	COPD (with Emphysema, Chronic Bronchitis)
H250	Congestive Heart Failure	Diabetes
H430	Congestive Heart Failure	Cerebrovascular Disease
H585	Congestive Heart Failure	Chronic Kidney Disease (Renal Failure)
H491	Congestive Heart Failure	COPD (with Emphysema, Chronic Bronchitis)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease (Renal Failure)
D491	Diabetes	COPD (with Emphysema, Chronic Bronchitis)
C585	Cerebrovascular Disease	Chronic Kidney Disease (Renal Failure)
C491	Cerebrovascular Disease	COPD (with Emphysema, Chronic Bronchitis)
R491	Chronic Kidney Disease (Renal Failure)	COPD (with Emphysema, Chronic Bronchitis)

Advantages
During the year, you may bill for as many office or home visits that occur. On six of those visits you can bill the additional complex care fees.

Disadvantages
If six face-to-face visits do not occur during the calendar year, the GP will not realize the full potential of this incentive.

All billable interactions must be face-to-face, and must directly involve the GP. This option is therefore more restricted than Option 2.

OPTION 2

- This option provides the same payment amount as the complex care fees under Option 1, but provides it as an annual payment in advance of the complex care you are expected to provide
- This advance payment is equivalent to six office visits, age-adjusted to the patient, to mirror the six visits that would occur if a GP claimed the full six Complex Care fees available under Option 1.
- The follow up visits may be conducted in person, or by telephone, or by email. However, the first visit (to create the major complex care plan) must be in person.
- Services other than the first care planning visit, may also be provided by a health professional other than the GP, such as a nurse.

Billing Summary

Option 2 – advanced lump sum billing (max six visits per calendar year)

Complex care fees:

G14033	Annual complex care practice fee (paid in one lump sum)	**$315**

- the first visit (to create the major complex care plan) must be in person
- the follow up visits **may** be conducted in person, or by telephone, or by email.
- services other than the initial complex care planning visit may be provided by a health professional other than a GP, eg a nurse.
- CPX fee (00101/16101/17101/18101) may be billed in addition to the block funding visit fee.
- Care for conditions other than those covered by the block funding visit fee may be billed separately

Annual complex care block fees:
(block fee equivalent to 6 office visit fees, but created especially for Option 2)

13135	Annual complex care block fee (age 2-59)	$167.40
13136	Annual complex care block fee (age 60-69)	$192.48
13137	Annual complex care block fee (age 70-79)	$209.22
13138	Annual complex care block fee (age 80+)	$217.62

Under both Option 1 and 2:

- CDM fees G14050/G14051 are payable on the same day for the same patient if all other criteria are met
- Community conferencing fee G14016 payable on the same day for the same patient if all other criteria are met
- for complex patients who live at home or in an assisted-living facility (excluding long-term care facilities)

1. G14033 Annual Complex Care Practice fee $315

To receive payment for this fee you must during the course of a calendar year:

(a) Create major complex care plan

The initial service allowing access to the complex care fees shall be the development of a Complex Care Plan for a patient residing in their home or assisted living (excludes care facilities) with two or more of the above chronic conditions. This requires documentation in the patient's chart that there has been a detailed review of the case/chart and of current therapies and a face-to-face visit with the patient or the patient's medical representative.

From those two activities a Complex Care Plan for that patient will be developed that:

- specifies a plan for that patient's care
- incorporates the patient's values and personal health goals
- outlines expected outcomes
- outlines linkages with other health care professionals that would be involved in the care, and their expected roles and an appropriate time frame for re-evaluation of the plan
- is recorded in the patient's chart
- is communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved health professionals as indicated

(b) Follow-up visits

Follow up care for patients under Option 2 may be provided face to face with the physician, by fax, telephone or e-mail or by allied health professionals. The advance block payment covers the provision of all services provided to that individual patient for the two qualifying conditions submitted for the remainder of that calendar year. There is no minimum or maximum on the number of follow up services that will be required under Option 2. Some patients may require more or less than 6 visits/services to provide the complex care follow up, but the advance block funding is equivalent to 6 visits.

Notes:

i) A Complex Care Plan must have been created, recorded in the patient's chart, and communicated to the patient and/or patient's medical representative and other involved health care professionals as indicated prior to billing for the advance block payments

ii) The advance block payment covers the provision of all services provided to that individual patient for the two qualifying conditions submitted for the remainder of that calendar year

iii) Services provided for unrelated conditions are not included in the block payment and are therefore payable in addition
iv) Complete physical examinations are payable in addition when medically indicated
v) Acute and Sub-Acute Hospital visit fees are payable in addition
vi) Payable once per calendar year.
vii) Not payable in same calendar year as G14030, G14031, G14032 on same patient;
viii) G14016, community conferencing fee payable on same day for same patient, if all criteria met
ix) CDM fees G14050/G14051 payable on same day for same patient, if all other criteria met

2. Use the age-related annual complex care block fees

Use the age appropriate annual block funding fee for the complex care services that the patient will receive during the calendar year. The age category for patient is determined by the age of the patient on the date the block fees are billed (Date of Service of the major complex care plan creation)

13135	Annual complex care block fee (age 2-59)	$167.40
13136	Annual complex care block fee (age 60-69)	$192.48
13137	Annual complex care block fee (age 70-79)	$209.22
13138	Annual complex care block fee (age 80+)	$217.62

Notes:
i) Payable once per calendar year
ii) Not payable in same calendar year as G14030, G14031, G14032 on same patient
iii) Annual Complex Care Fee (G14033) must be billed on same date of service
iv) A Complex Care Plan must have been created, recorded in the patient's chart, and communicated to the patient and/or the patient's medical representative prior to billing for the advance block payments
v) The advance block payment covers the provision of all services provided to that individual patient for the two qualifying conditions submitted
vi) Age category for patient is determined by the age of the patient on the date the block fees are billed (date of service)
vii) Complete physical examinations are payable in addition when medically indicated
viii) Acute and sub-acute Hospital visit fees are payable in addition
ix) G14016, community conferencing fee payable on same day for same patient, if all criteria met
x) CDM fees G14050/G14051 payable on same day for same patient, if all other criteria met

3. Use the ICD9 codes listed in Table 1

Diagnostic codes have been developed to cover all combinations of any two of the chronic conditions covered under the complex care fees as described earlier. (Refer to page 5)

Advantages

The provision for non face-to-face interaction provides more flexibility with a population that is generally less mobile and therefore less able to travel to the GP's office.

Allowing interaction with health professionals other than the GP also provides more flexibility and allows for a broader range of practice styles.

In moving to planned care the patient may not need all six interventions for the two specified conditions.

Disadvantages

Payment for the equivalent of six visits in one calendar year, as payment in full for the two specified conditions, introduces the risk that the patient may need to be seen more than six times per calendar year (e.g. monthly). This is mitigated by the fact that unrelated conditions are still billable, as are appropriate complete physical exams.

Age range of complex care block fee is determined by age of patient on the date it is billed. If the patient changes decades (eg from age 69 to age 70) later in that calendar year following the billing of this block fee, no adjustments are made to increase the value.

BRITISH COLUMBIA
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Preventing the Onset of Chronic Diseases

As part of the 2006 Working Agreement, the General Practice Services Committee (a joint committee of the B.C. Ministry of Health, the B.C. Medical Association, and the Society of General Practitioners of B.C.) has developed the following initiative to improve disease prevention.

G 14034 Cardiovascular Risk Assessment Fee: $100

This fee is payable on the completion of cardiovascular risk assessment of an individual using the parameters of age, gender, smoking status, fasting blood sugar, blood pressure, and lipid profile as a minimum. More detailed assessment parameters could include family history, waist circumference, diet, alcohol use, exercise levels, and stress levels.

Notes:

i) the eligible population will be males ages 40-49, women between 50-59;

ii) a chart record is required that includes the minimum parameters above and evidence of an appropriate response to major high risk findings, including interventions, prescriptions, referrals to appropriate health care professional and/or linkages with community supports;

iii) interventions should be aligned with the current guidelines published by the Guideline and Protocol Advisory Committee (GPAC); eg. Diabetes, hypertension, lipids;

iv) payable for a maximum of 30 patients per physician per calendar year;

v) Payable in addition to office visit fee(s) billed same day

vi) Payable once per calendar year per patient.

This assessment is intended to assure that major guideline-recommended measurements are made for appropriate age groups; a specific % 10 yr. M.I. risk assessment is optional. The essence of the activity is that the family physician discusses with the patient the major risk factors and their presence or absence.

Eligibility

- Payable only to the General Practitioner or practice group that accepts the role of being Most Responsible for the longitudinal, coordinated care of the patient for that calendar year;
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months;
- Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care;
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

Rationale

Person/Population Focus

Over one million people in British Columbia currently live with one to three chronic diseases. Almost half of the population is at risk for and/or has been tested for a chronic disease. A key response to the demographic and disease trends towards an increasingly older population with more chronic diseases is to invest in strategies that will prevent or delay the onset of chronic diseases. There is growing evidence that this is possible. According to the World Health Organization, 80% of the cases of some chronic diseases such as Type 2 diabetes can be prevented. Research has found that moderate exercise and diet control among overweight people with pre-diabetes (impaired glucose tolerance) reduces the likelihood of developing diabetes by more than 50%. Many chronic diseases such as diabetes and cardiovascular disease have similar risk factors. Addressing these common risk factors, reducing tobacco and alcohol use, eating healthily and being active underlies the logic for the cross-government ActNow initative. However, despite the evidence, for many people understanding and making healthy choices remain elusive. People are faced with life-time habits, lack of resources or family/social supports, or life's pressures that make "adding something else" impossible. Personal change needs the same support as professional change i.e.:

- to receive and understand personal data to show the outcome of remaining with the status quo;
- to learn evidence-based approaches that have worked for many other people
- to put those approaches into action with others (buddy, group, family)
- to measure results and be accountable for these results to others

Physician Focus

Family physicians want to provide their patients with preventative care. The role of the family physician in prevention is twofold: (a) very influential health professional and (b) facilitator. Most physicians can already identify these patients in their practices. The family physician can use a variety of tools to assess risk of chronic diseases – and share these data with the patient. The focus of this initiative is to more formally introduce the process of cardiovascular risk assessment and follow up to family practice.

Health System Focus

The current health system is not linked to community resources in a way that supports health improvement for the majority of the population. Most communities have infrastructure, services and resources that can provide support to people who want to quit smoking, reduce alcohol intake, improve their diet and increase their activity levels. However, these resources are not often linked together and are very rarely formally linked to primary health care. Family physicians and their patients are not going to succeed at very difficult life changes for health if supports and expertise are not readily available. To this end GPSC has linked with Health Authorities and the BC Healthy Living Alliance – responsible for creating an effective infrastructure in communities to supply people, identified as being at risk of developing chronic disease, with tools, supports, and opportunities for healthy change.

Community infrastructure for overall health must be clearly identifiable to family physicians and their patients. Therefore, regional change teams put into place through GPSC non-compensation

funding will be required to provide physicians with direct facilitation support and/or referral information for each community. In addition, family physicians wishing to take on the direct facilitation role with their patients will also be supported and trained in group patient visits.

Principles for the Prevention Payment

- Focus on the patients at greater risk for the onset of chronic disease
- Achieve equity of access to improved health status for patients. Horizontal equity refers to similar public funding for patients with similar needs. Vertical equity refers to more support given for patients with greater need;
- Reward the intervention and knowledge of the family physician with direct facilitation and/or referral to information and community-based services
- Retain and encourage family physicians already providing preventative care and encourage general practitioners currently targeting patients who have relatively straight forward clinical needs to take on their greater share of at risk patients.
- **The 2007 GPSC approach to prevention is experimental. It is understood that not all higher risk patients will be identified through this initiative. GPSC will work closely with Family Physicians to determine the effectiveness of this incentive from the perspectives of patient, provider, and system, and retains the right and authority to modify this incentive based on results. It is anticipated that future initiatives in preventative care will evolve through ongoing input from Family Physicians**

eHealth matters

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Updates and news from British Columbia's developing eHealth projects for those working on eHealth projects and initiatives

eHealth and PharmaNet — Building Electronic Health Records for B.C. Residents

The vision…

To improve the delivery of patient care in British Columbia by expanding the use of electronic medication information management to facilitate seamless care across all care settings.

The plan…

To upgrade and enhance the existing well respected PharmaNet system, and integrate its services with eHealth components.

As described in our previous eDrug Project Progress Update*, PharmaNet—the province-wide computer network linking pharmacies and other health care sites to a central Ministry of Health database—will soon be significantly upgraded as part of the Ministry of Health's eHealth initiative.

Our last report focused on how eHealth will affect PharmaNet and how patient information will continue to be secured. It also identified the key players in the eDrug Project. In this report, we'll focus on related eHealth projects, discuss some of the benefits of the eHealth initiative, provide more detail on specific changes to PharmaNet, and update you on current activities.

* Issued in the November 17, 2006, edition of the PharmaCare Newsletter at www.health.gov.bc.ca/pharme/newsletter/index.html

How does the eDrug Project fit into eHealth?

eHealth is the overarching term used to describe electronic health services delivered or enhanced through secure, shared Electronic Health Records (EHRs). eHealth supports and enables a more effective, integrated and coordinated approach to information sharing among all health professionals and health organizations. The provincial EHR is an integrated record of a patient's medical information and will include information such as medication history, lab results and diagnostic imaging information. Physicians, pharmacists and other health care professionals will have authorized and secure access anywhere, anytime, to only that information in an individual's provincial EHR that they need to know in order to provide safe and appropriate care.

OTHER eHEALTH PROJECTS

The eDrug project is tightly linked to other eHealth projects that will bring together information vital to effective EHRs. These include:

Interoperable Electronic Health Record (iEHR)—The iEHR routes clinical messages between Point of Care systems and eHealth repositories and enables authorized access to eHealth information.

Provincial Laboratory Information Solution (PLIS)—Will provide a comprehensive repository of patient lab test results to authorized clinicians.

Connecting Digital Images (DI)—Connecting DI will provide seamless access to diagnostic images and reports to authorized users regardless of where in B.C. the exam took place.

Electronic Medical Record (EMR)—An EMR is a physician office-based system used to store and retrieve clinical information about patients in that practice. Physicians will be able to use their EMR systems to access the full provincial EHR including ePrescribing.

The eHealth initiative will develop the infrastructure and interfaces necessary to collect and store provincial EHR information in central databases where it can be securely accessed by authorized health care professionals such as physicians and pharmacists. The eDrug Project will deliver the enhancements to PharmaNet resulting in more complete and securely accessible medication histories in the provincial EHR.

What is ePrescribing? Where does it fit in?

A key enhancement to PharmaNet under the eDrug Project is the introduction of electronic prescribing ("ePrescribing").

ePrescribing will be implemented in alignment with the Electronic Medical Record (EMR) project (see sidebar), allowing prescribers in medical offices throughout B.C. to enter prescriptions into their EMR system and have them automatically transferred to PharmaNet. PharmaNet will check the prescription against the patient's existing medication profile and identify potential issues such as drug interactions or allergies. Any problem can then be dealt with by the prescriber immediately.

Community pharmacies must be able to pick up prescriptions through the new PharmaNet system before prescribers can take advantage of the ePrescribing capability. We anticipate that the new system will be deployed in pharmacies starting in 2008.

Will there be changes to the claims component of PharmaNet?

Yes. Changes to the claims component will enable ePrescribers and pharmacists to view the PharmaCare benefit status or Special Authority criteria applicable to the drug they wish to prescribe or dispense to a patient. Processing of most Special Authority requests will save time for prescribers and add convenience for patients. A new messaging standard will allow for greater detail in the information entered and stored in PharmaNet.

Benefits to Patients and Health Care Professionals

The benefits of the eDrug Project include:

- **Enhanced patient safety**—Fewer adverse drug events as a result of more complete medication profiles and more accurate communication of prescriptions.
- **Improved coordination of care**—Greater continuity of medication care across all clinical settings will be possible.
- **Reduced treatment delays and faster delivery of care**—Health care providers will be able to quickly address drug allergy or drug interaction issues and will have access to PharmaCare coverage information.
- **Enhanced decision making**—Health care providers will have access to complete patient medication profiles and treatment history. Online clinical support tools will alert health care providers to potential clinical issues.
- **More efficient use of health care providers' time**—Reduced calls between prescriber's offices and pharmacists to clarify handwritten prescriptions.
- **Empowered patients**—Patients will be able to participate in their care by monitoring and, in the longer term, contributing to their medication record.

What activities are underway?

- **Keeping stakeholders involved**—
  - **eDrug Pharmacy Advisory Committee**—In January, the eDrug Pharmacy Advisory Committee was formed to provide recommendations and business input to the Assistant Deputy Minister of Pharmaceutical Services, including implementation plans. This vital stakeholder group will advise on the matters that are most important to the community pharmacy sector. The Committee includes representatives from the College of Pharmacists of BC and the BC Pharmacy Association.
  - **eDrug Steering Committee**—In January, the committee welcomed its newest member. The Committee now includes a representative from the College of Registered Nurses of BC.
  - **eDrug Clinical Working Group**—This group includes representatives of health authority pharmacists, the College of Pharmacists of BC, the College of Physicians & Surgeons of BC, the College of Registered Nurses of BC, the BC Medical Association and the BC Pharmacy Association. The group is working closely with the Ministry's system integrator to confirm the business and configuration requirements for the enhancements to PharmaNet.

What activities are underway, continued

- **Planning eHealth Deployment with Health Authorities**—Representatives from the health authorities have been involved in integrated eHealth deployment planning workshops over the last few months. In our next newsletter, we'll update you on the outcome of this important planning activity.
- **Working with software organizations**—To ensure the transition from existing community pharmacy software to new pharmacy software is as effective and efficient as possible, we continue to work with the organizations that supply or support pharmacy software. Our recent information sessions provided these organizations with an overview of planned enhancements to PharmaNet and with the initial implementation guide. Adoption of the new pan-Canadian clinical and financial messaging standards for the exchange of electronic medication information is a significant change for these organizations so we are providing as much lead time as possible.
- **Expanding PharmaNet Access**—Expanding access to PharmaNet is a fundamental component of the eHealth and eDrug vision for sharing health information. Hospital Access to PharmaNet (HAP) is the expansion of access to the existing PharmaNet system for physicians and pharmacists in hospitals and designated mental health facilities. This new service is a key stepping stone to the provincial EHR as it enables health care providers in these facilities to access a patient's medication record on PharmaNet.

Let's stay connected!

Please direct your questions, comments or ideas for this newsletter to the eDrug Project team at:

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